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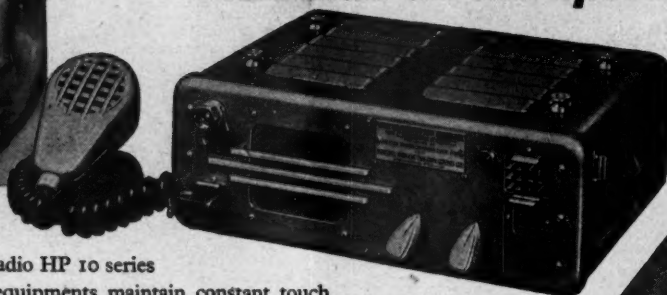
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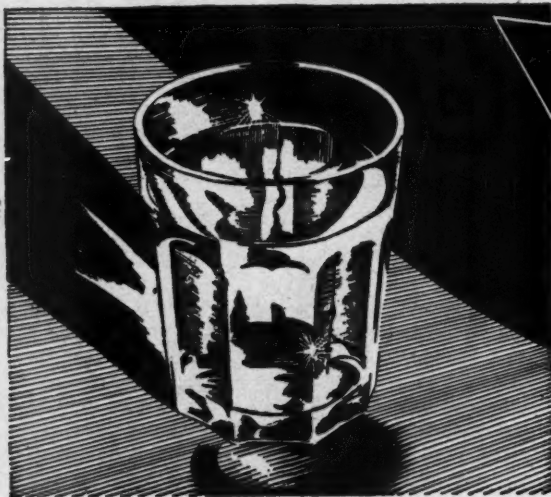
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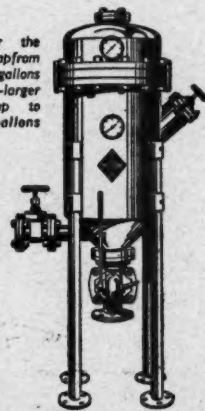


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EDITORIAL

A Thousand Georgie Families

Like Xenophon's ten thousand Greeks, the "thousand families" of Newcastle* have now come into the public consciousness after a period of several years during which hints of this study have been coming to the ears of the medical world. The widespread attention given in the Press to the report now published is a tribute both to its intrinsic interest and to its prime mover (the others will not begrudge this), the late Sir James Spence, who we are glad to think must have seen the final proofs of the book before his recent lamented death. The other outstanding feature of this study will be for many of us the complete degree of team-work between university, health department, hospital and general practitioners which was demonstrated, more so than in any previous field research.

The inquiry started as an attempt to measure the morbidity of the 1,142 babies born in Newcastle upon Tyne in May and June, 1947, known as the "Red Spot" babies because of the legal seals used to identify their records. Soon, however, its scope widened until it became the "thousand-family" inquiry, as it became obvious that the main source of first-year illness was intra-family infection. What is more, this book, which covers the first year of the infants, or in some matters the first 15 months, makes also a revealing picture of the Newcastle social background, living conditions and standards of maternal care. Newcastle, because of its geographical position and its history, has perhaps a more distinctive "character" than other British cities. Likewise its health services have developed on their own lines; there has never been more than one whole-time medical officer for maternity and child welfare, but on the other hand we get the impression that the relations between the branches of medicine have been closer than elsewhere. Thus, whilst the findings of this study might not necessarily be applicable to other communities, the clinical discussions, for instance that on whooping cough as closely observed by this skilful team, are of universal value. The technique developed by the team of tracing the path of infection

within the family or within the house (possibly shared with other families) should also inspire others to do likewise. Chapters which should particularly interest the public health service are those on the medical care of illnesses in children and the use made of the infant welfare centres; Dr. Miller's first note on this subject has already produced a crop of useful self-criticism. On the other hand, the authors' conclusions and suggestions give less than due credit (perhaps because of Newcastle's special circumstances) to whole-time M. & C.W. medical officers for the past decline in infant disease and mortality, though the work of health visitors is generously recognised. Another conclusion, that there is a limit to the effective results which the "traditional agents of housing, health education, and sanitary reform can achieve in the further prevention of disease in childhood," is open to argument and would certainly not be accepted by the public health service as yet in other industrial areas; but we agree that future progress will be more rapid if family doctors, better trained in the principles of child health, "co-operate with the traditional agents of preventive medicine."

We congratulate all who took part in this valuable and meticulous survey, not forgetting the M.R.C. and the Nuffield Foundation and Provincial Hospitals Trust, which aided with staff and finance, and the health visitors and other members of the health department staff, whose part was essential.

We conclude with one minor question: Why is "public-health" throughout this book, as in much WHO literature, now given a hyphen between the adjective and the noun? This is one of the modernisms we do not like.

Installation of President, 1954-55

Dr. Jean Mackintosh will be installed as President of the Society for the coming session and will deliver her presidential address at an Ordinary Meeting to be held at the London School of Hygiene and Tropical Medicine on Thursday, September 16th, at 5.30 p.m. It is hoped that as the first lady President of the Society she will be supported by a large attendance of members on this occasion. A notice about the cocktail party which will follow this meeting appears on the Monthly Circular enclosed with this issue.

* "A Thousand Families in Newcastle upon Tyne." By James Spence, W. S. Walton, F. J. W. Miller and S. D. M. Court. (Pp. 217. III. Price 10s. 6d.) London: published for the Nuffield Foundation and Nuffield Provincial Hospitals Trust by Geoffrey Cumberlege, Oxford University Press. 1954.

MEDICAL ADMINISTRATION *

By E. D. IRVINE, M.D., D.P.H.

Medical Officer of Health, City of Exeter.

"Their motto should be *Respice, circumspecte, aspice et prospice*." (Arthur Symons, *The Spectator*, 24.4.1848) (referring to the legislator and the administrator).

"The health of the people is really the foundation upon which which all their happiness and all their power as a State depends." (Disraeli 1877).

Definition

Administrative medicine and medical administration are terms commonly used synonymously; and yet there is a shade of difference in the emphasis: the former suggests a phase of medicine which is administrative, whereas the latter suggests a phase of administration which is medical.

Administrative medicine has been defined in America in this way—

"Considering the application of the medical sciences systematically as they are availed of today, we have the broad distinction between those activities which are carried on by the skills, equipment, and initiative of the individual physician for the patients or their families who have sought his aid to restore or protect their health, without any financial or other intermediary or associate, and those which involve a number of persons related to each other by authorised organisation, be it institution or agency, for the delivery of service to individuals and groups, or to whole communities or national populations. This latter is what we include under the term 'administrative medicine.'" (Emerson, 1949).

To many people medical administration implies administration which is, in fact, carried out by medical men engaged in public service. But we must go further. Is there any need for a doctor as administrator; in which work is he necessary or desirable; what principles govern medical administration?

The provision of any community service can only be achieved by organisation and administration. In this country with our National Health Services, community health care can only be provided through public administration, and as I hope to show, that, so far as health care is concerned, should be based on expert medical knowledge.

My definition of medical administration would be—

"that phase of public administration which is concerned with the provision by the community of health care for the individual or the community as a whole and which is based on medical science and skill."

What is the content of medicine? What is the purpose of administration? Among many other definitions the Oxford English Dictionary gives for medicine "that department of knowledge and practice which is concerned with the cure, alleviation and prevention of disease in human beings and with the restoration and preservation of health"; and for administration "the management of public affairs, the conducting or carrying on, the details of government."

Nowadays, we must recognise medical care as a continuum and not as a series of disconnected efforts, whether considering the community or the individual. It is this aspect of medicine, no longer to be thought of as episodic, that makes the medical elements in public administration so important and which makes administration significant to medicine.

All concerned with the public health must be affected by the realignment of ideas necessitated by the development of social science. Poverty and illhealth are notoriously associated. Adverse social circumstances may cause psychological disturbance and psychosomatic disorder; and psychological disturbance, mental illness or intellectual defectiveness, may in itself lead to social disequilibrium; a medical background is demanded of those aiming to solve the problems they cause: a social science background is not sufficient. But that is not to deny the importance of a knowledge of the forces inherent in our community—in its own time and place—which affect individual, family and

community well-being. Clinical and laboratory medicine alone have little application in most community problems unless conjoined with an understanding of the social scene, strains, motives and even economics, and unless made available through administrative procedures. And for that reason sociology must increasingly take its place among medical studies. The changing emphasis in publicly organised medicine from improvement in the physical environment, to care for individual defects, to treatment for psychosomatic disorders, and now to interest in the health problems of the family, is evidence of success in our work and a pointer to the future. So that among the associates in the Community health field, social workers must take an important part, including people with a knowledge of social case work. This is an expression of the need for medical direction of workers not in themselves medical, but trained in a science or skill subserving the end of medicine.

Principles of Public Administration

Now to turn to public administration as a Service. It has grown up, partly based on principles and partly on historical accidents, and very much according to convenience.

We would do well perhaps to remind ourselves of the major principles of public administration as a Service because they do affect medical administration: (1) that it is the instrument of the public will to effect changes in social conditions, (2) that it is subject to the political authority, (3) that it is ultimately accountable to the public, (4) that it must stand in close relation with public feeling, (5) that it must produce the best possible results at the least possible cost, (6) that it operates (as do all social organisations) by division of labour and organisation, (7) that research and evaluation of results are necessary. (Warner 1947), (Finer 1950). As securing health and safety (public and international order) is the main purpose of Government, public administration must be concerned with every field of health, but it should only become executive in so far as self help and voluntary help fail. State action tends to uniformity and inflexibility and is almost inevitably limited to making the worst better and it may even operate to make the existent best not quite so good. Centralisation in itself is an undesirable change, and existing authorities should not be replaced by larger ones without good cause, nor new ones created, if that can be avoided. *Entia non sunt multiplicanda praeter necessitatem*. Newsholme (1936) says the creation of ad hoc bodies to deal with what are essentially health problems has always been a handicap to the proper co-ordination of the health services. This has relevance in our day to the welfare and children services.

Public Administrators—Central and Local

It is clearly acknowledged that in the Central Public Service the administrative grade—recruited since 1870 fresh from the Universities with a generalised and not a vocational education—is responsible not only for securing that the directives of the Ministers of the Crown and Parliament are carried out, but also for ensuring that the Ministers are fully and precisely informed and advised on all matters likely to be discussed in Parliament, both as to public demand and public needs (not the same things), cost, collateral effects and many other things. This is not to say that the Civil Service is the sole source of information nor the sole element in policy making. The Administrative grade present a Civil Service opinion, an independent view, and act as a check to democracy (*Times*, 23.11.53). In my view, the best security against improper and excessive political pressures on the Health Service is secured by a medical administration. It is sometimes asserted that the committee system in local government obviates the need for an administrative grade comparable with that in the Civil Service; but in my view, there is such a grade, viz:—the chief officers and their senior advisers and assistants, who, however, are recruited at later ages, on the basis of vocational training and experience. The assessment of public needs, in relation to health and community health services, whether at national or local level, demands well

* Paper read to the County Borough Group, Society of M.O.H., Torquay, May 22nd, 1954.

conceived investigation and enquiry, a receptiveness to abnormal patterns in health statistics, and a widely organised listening-post system, and implicitly requires medical training and experience.

The increasing subjection of local government to the central authority during this century and notably since 1939, in an effort to provide more uniformly, through the country, social services of a better general average has, nevertheless, still left opportunity for divergences in the local services. Local authorities are by no means all equally progressive. The chief officers of local government authorities can and still do materially affect the services available to the people, because they can and still do materially affect the decisions of the local councils, just as the administrative grade in the Civil Service affects the decisions of the Ministers of the Crown. It is true that the local services are increasingly executive in character, but the advisory and not the executive duties of the chief officers are still of primary importance. Of course, local authorities administer many Acts of Parliament, but to say that the councillors are administrators in our sense of the word is to change their significance as elected representatives responsible (as is Parliament) for decisions on policy (though in a subordinate sphere, within the existing law, rather than in its making), to a status quite different. They are administrative only in the same sense that the Ministers of the Crown form the Administration. As I see it, the administration of the health services (in their widest connotation), is not merely the carrying out of a predetermined policy—it is the process of deciding what is desirable, what is necessary, what is practicable, of advising and so far as is proper, persuading the political authority, whether local or national, that that advice should be translated into action, and then ensuring the effective carrying out of the directives issued by the political authority.

Staff and Line

In administration we think in terms of "staff" and "line." The "line" is the personnel concerned with carrying out the principal task of the organisation and, therefore, qualified to do so; it carries the direct chain of command from top to bottom; while the "staff", comprising professional and technical experts, advise at all levels in their own specialties. The "staff" is not executive except that it may have its own "line" in its own department. Its advice may be rejected by "the line," or modified or accepted in full, but "the staff" act only in an advisory capacity, and have (apparently) no absolute right to a hearing by the ultimate authority of the department (in the Civil Service, the Minister).

The Health Services

Let us look at the health services, recognising throughout that many public services never included in the term, substantially contribute to healthy environmental circumstances.

Central Departments.

The central departments deal with health services clearly involving medical personnel and ancillaries as the *main* components responsible for the starting point of care, including the hospitals, the general domiciliary medical and allied services, the local health authority services, the school health service, the mines' medical service, the factory medical service, the medical service of the Forces and others. It is a sad reflection on the British Medical Association's understanding that it has so strenuously pressed for a Ministry of Health concerned only with the almost strictly *medical* services, a weaker Ministry than it was and not covering (as indeed it could hardly cover) all the medical elements in public work. Clearly, the senior medical staff of the Ministry are administrators, and not merely executives: they have regarded advice and policy making as the major purpose of their work; but it appears that even in the Ministry of Health the medical staff are very much "the staff," the non-medical administrators being the head of "the line." The discontents of the Chief Medical Officers have been many times referred to; Simon complained in relation to the formation of the Local Government Board in 1871 that a "further adverse circumstance was that Mr. Stanfield set out to make the medical department of the Board subordinate

to lay control and did not entrust it with any substantial share in the creation of the Board's health policy or practice." (MacNalty, 1948). It was a grievance of Newsholme (1936) that "expert views were not adequately expressed up to the moment of decision," and he speaks feelingly of "the assumption of secretarial and legal omniscience." But have there not always been many "men who to all the world seemed clever, very. As long as they had a clever secretary"? (Kryloff's *Fables: The Oracle*—Trans. B. Pares); and examples have been quoted by Newsholme, where medical advice, had it been accepted, would have led much earlier to a co-ordinated system of medical care. One wonders whether it was advice from non-medical or from medical administrators that was responsible for the division of the national health service into three component sub-administrations, a constant source of weakness. Where, as in the Ministry of Health, the main objective is protection of the health of the community, there is, surely a good case for a medical administration of the department with the necessary political, legal and financial control secured by the Minister and the Treasury. Although in this country the idea so far is unacceptable, it is not so, I believe, in some younger nations. Surely, if the principle of staff and line is a right one, it would require in the Ministry of Health the primacy of *medical* administration.

Hospitals.

Coming down the scale, the hospital service has, in theory at least, in each Regional Board (though not in the Boards of Governors), as chief administrative officer a doctor; the title (Senior Administrative Medical Officer) does not quite imply that—a pity! As for each group of hospitals, non-medical administration reigns supreme, a result secured mainly by medical pressure. The multiplication of medical and other committees in the hospital service offends the principle of "least means" in administration and is a wasteful method of securing authoritative medical opinion. Nevertheless, there is, I think, a good deal to be said for small permanent committees representative of different aspects of hospital work to give general leads on hospital policy, but the day to day decisions on detail should be made by a single person and that a doctor—a medical administrator. The inability of non-medical men to weigh up evidence of the medical necessities of patients is undoubted and recourse is had to these multitudinous committees meeting at greater or less frequency, as opposed to the rapid decisions (admittedly not always right) of a medical man in administrative charge. The Army does not entrust its hospitals, not even their provisioning, to non-medical officers, but the Army in this, as in its respect for preventive medicine, shews more sense than the civilian authority. In the Army as a whole, however, as might be expected, M (Medical) is subordinate to A (Administration) which is subordinate to G (General fighting and training).

We should not decry the work of the hospital secretaries who have been zealous. The hospital service in many ways has much improved. The non-medical system of administration was adopted because the voluntary hospital service and the consultants did not like the municipal hospital system which in many areas was rapidly overtaking in public esteem the voluntary hospitals. The consultants objected to the principle of a single medical voice in high authority, forgetful of the basic unity of medical thought in the welfare of the patient. When much of the hospital service was managed by local authorities it was administered by medical men, subject, of course, to political control which in most areas was, in health matters, generally free from party strife though not always from political unwisdom. Financial, legal, architectural and other advice was always readily available at a minimum of cost. But above all, the welfare of the patients, as sick and sometimes frightened people, was the first care of clinician and administrator alike, both with a common basis of thought and experience, and speaking the same language. Dr. H. M. C. Macaulay (1954) experienced in both systems, has said that the business side has been confused with the hospital itself; and that the result of the present system in many hospitals so far as it concerns medical administration of the hospitals is anarchy.

It will be remembered that the Dawson Report (1920) advocated a medical administration of the clinical health services, including the hospitals, as well as the rest of the environmental health services, by the Medical Officers of Health of reconstituted large local authority areas as chief administrators. It may be that the present system is what was practicable in 1946 in relation to public feeling, but we may take leave to doubt that. Certainly, many consider that non-medical administration of the hospitals has led to much greater expense with less efficient service per quantum of cost. And we should declare our conviction that the hospitals would be more satisfactorily organised if they were under medical administration, though *not necessarily* by medical officers of health; for some hospitals that is probably still the best arrangement, distinguishing always between clinical and administrative control.

General Practice, etc.

With regard to the local administration of the general practitioner and allied services, it is clear that the present detailed administration at this level is very much an automatic one, dependent on precise central direction. If local discretion of any magnitude (apart from appeals and complaints) were to be devolved then it seems clear medical direction at this level would be essential. The principle that only medical men can clearly interpret medical issues, which are the important ones in health services, should be established.

Local Government Health Services.

Turning now to local government organisation of local health services, I must say at the outset it is not my intention to discuss the varying problems in medical administration met in different kinds of Local Authorities. They are important, but do not affect the principles I am trying to elucidate. I suppose nothing has incensed medical officers of health so much as the view attributed to the Local Authority Associations in 1951 that medical officers of health were but administrators with medical knowledge, implying thereby a total dissociation from the main stream of medicine, and a mainly executive function. On the other hand, some town clerks and county clerks postulate that medical officers of health are concerned only to give advice, but should not have any executive administrative functions. *The Times* (4/2/54) supports those who suggest that the Clerks should have a co-ordinative and supervisory role in relation to all the other departments. Such a relationship would inevitably ultimately lead to the subjection of the other departments to that of the Clerk. This change was also more cautiously advocated by members of the O. and M. Division of the Treasury recently in relation to Coventry; it is evident they believed such a change of function and status in the town clerk (from *primus inter pares* to chief co-ordinating executive officer) would substitute for the so-called vertical structure of the local government service a horizontally tied administration somewhat akin to that of the central departments. But whatever we may think of all this, we cannot shut our eyes to the fact that, as indicated in *The Times* leader "A Town Clerk's Duties" (Feb. 4th, 1954), local authorities increasingly regard administration in its narrow sense of management of personnel and work in a department as the main function of the chief officers—a view which we must endeavour to modify; nor can we deny that faulty methods of management will most surely lead to the supersession of the professional chief officers, appointed for their professional qualifications, experience and outlook rather than training in management, by others regarded as practical administrators.

At present, local government services cover the environmental and personal health services; the function of the latter is gradually being changed from active clinical work to the provision of an ancillary service supporting the practitioners, and in the case of pre-school and school children to a defect finding and health education service, though it should be noted that the obligation to provide adequate clinical dental treatment of school children has had to be introduced into the amending Education Act, 1953. The main purpose of the organisation has been to protect health; the doctor has been given the primacy in administration: this applies not only to

medical and related services in the personal health field, but also to environmental sanitary control, in fact, wherever the primary aim has been health protection. Where, however, the problems are largely mechanical, demanding engineering knowledge rather than medical—and this applies to the provision of water supply, sewerage, sewage disposal, refuse disposal, and some other services which tend to the health of the community—the administrative line is not medical though here the public health service has "staff" functions. The same applies to house building though slum clearance, as primarily a health measure, has been entrusted to the medical officer of health and his department. Is the doctor the right person to administer the "sanitary" services? Well, modern public health grew up largely because the infectious diseases were principal causes of sickness and death, because it was recognised that sanitary circumstances affected the spread of infectious diseases (as shown by Southwood Smith as long ago as 1830), and later because bacteriology (accepted as a medical science) illuminated the epidemiology of the infections. Poverty, bad housing, dirt, drink, and ignorance were recognised as potent though not the only causes of ill health; for even in the last century personal discipline and right behaviour were accepted as necessary to the promotion of health, and poor law relief was given conditionally on such conduct; and today, fresh appeals are made for the same attitudes in relation to personal health. Slum clearance, food preparation hygiene, and smoke abatement, three major duties of the sanitary service, are clearly community health protection and depend on medical knowledge. The argument in favour of medical administration of the sanitary service lies, it seems to me, in the need for unification of all the services based on medicine, contributing immediately to the preservation of the health of the people. Where there is a personal approach to an individual, in matters of health, then it is a matter of medicine. Everything that affects the health of the family in its home should be of concern to medicine. And in community medicine medical control is essential.

There can be no argument about the necessity for medical administration, both advisory and executive, in the school health service—nor about our relationship as advisers to the Education Authority and the chief education officer in regard to environmental factors in the schools.

Is medical administration necessary for the best management of welfare services, including the welfare of the aged, and the handicapped and of the Children's Service? The Ministry of Health evidently think not. But since the social disabilities of the aged and handicapped stem directly from their mental and physical disabilities, quite clearly best comprehended by medical men, I would argue that the administration of these services is best conducted by medical men interested in social medicine; continuity of care for the handicapped would alone be a compelling reason. Similarly, the care of children permanently deprived of a good home is surely designed to give them satisfactory mental adjustment, as well as physical health, both most understood by doctors—at least by doctors aware, as we may claim we are, of the significance of psycho-social difficulties and of the environment in its widest meaning.

The Medical Officer of Health as Adviser and Executive

I accept entirely Parry's argument about the importance and primacy to Medical Officers of Health of a specialist training and knowledge in preventive medicine, and especially in epidemiology. But we are the experts in *organised* preventive medicine as well as in the application of preventive medicine to individual circumstances. And although as I have said, I regard our advisory functions as the more important, the executive side of our work cannot be denigrated or abandoned. Unless the control programme, in relation to problems of community health, is, once the political decisions have been secured and the money allocated, in the hands of the doctor as administrator, he loses both the experiences in action necessary to plan control measures in a realistic way, and the experience necessary to evaluate their results—for he has no other innate standing in the matter; but, also, the

medical and, therefore, the health bias of the programme and its relation to what has gone before and what is to come after are in danger. He alone can relate the value of any particular phase to the overall programme of the health department; he must also be in a position to inject new impulses that may be necessary from time to time, redirecting the effort in changing circumstances. Those unversed in Medicine (and especially Social Medicine), including the experts in organisation and methods, office techniques and costing, cannot be expected to, and, in fact, do not, stretch the programme to meet individual needs; they are not trained to evaluate such needs in terms of health; they administer a system based on mathematical ideas in a mechanistic way, not on social and health needs.

Dr. John Gordon (1954) of New York, after discussing epidemiology as a discipline, has said,

"Actual control operations are the central point in the process of solving a health problem. The procedure so far described is comparable to an assembling of ingredients: what comes now is the baking of the cake. . . . Realisation of the control programme is the obligation of the public health administrator acting as the agent of society."

In my judgment, unless the doctor controls the organisation he cannot hope to be effective in his role as epidemiologist, nor has he the standing to get the all important co-operation from the rest of the profession and the public. You cannot, I believe, have an epidemiologist, so to speak, in the air. If he has no organisation, he has no standing, he has no help. And though the day of the lone hand investigator is not over, his chances of success are more limited, I believe, than in the past. And contrary to what Parry (1948) has said, I believe it quite impossible, such is human nature, to have satisfactory epidemiological study (whether in infectious disease or the wider field of morbidity and mortality) without a stake as an officer (not necessarily the Chief Officer) in the organisation to which the records belong. The loss of hospital services affected public health officers profoundly and adversely, for, by and large, hospital records are not now readily accessible to him.

Parry, as I read him, wants the medical officer of health to have general supervision of the health department, but not detailed executive power; to cut the Gordian knot of administration: but he repeats Newsholme's warning of the dangers of this course. The fact is, without ultimate power, general supervision is a myth.

Our organisation, with our staff's access to the homes of the people (freely allowed) and to the children at our authorities' schools and clinics, is to us the counterpart of hospital beds to the consultant. And, once the consultant has lost his beds, no matter how experienced he is, his practice and his usefulness rapidly fade away. In that there is a warning.

Nevertheless, we must distinguish between the routine technical elements of administration, especially organisation and methods including office techniques, mechanisation, pooling of services, records and forms (in which, however, the medical element may be most important), filing and costing, and those which demand a wide philosophic and humanistic approach, an experience both of men and affairs, and in health matters, a medical experience, basically scientific, clinical and sociological. We should know enough of the former, including the technical elements of organisation and method, and only so much, as to enable us to know that in our departments those deputed to carry them out are doing so. We are not immediately, but only ultimately responsible for them. We must retain a close interest in personnel management, and responsibility for the solution of establishment problems relative to the health services of our own authorities. Picking the team, and internal diplomacy are important duties.

Failure to accept responsibility for these executive functions leads the way to subordination of the medical interest to the financial and organisational elements in the Department.

Co-ordination—Hierarchy and Team Work

Medical administration itself involves co-ordination of the work of different professions, all associated with medicine, all having different disciplines, different levels of training, capacity, and social standing. The health visitors cannot

work in isolation from the sanitary inspectors, from the mental health workers, from the midwives and home nurses or from the home helps. They all serve in different ways and degrees the health of the family. The chief administrator cannot allow them all to go different ways regardless of each other. He must co-ordinate their work, and in health matters it is a doctor's duty to direct their activities as a whole, to find out the needs of the area and determine the changes in practice that should occur with the passage of time and in new circumstances. Each group will have its own head, but the medical officer should lead the whole.

Medical leadership is essential. Dr. W. R. Willard of New York says of this (referring clearly to national and local needs),

"there is an urgent need in many communities for sound, regional planning by competent medical and community leaders to secure, distribute and co-ordinate local facilities and trained personnel that are requisite for proper health services. The essential feature of any well-conceived programme is the quality of the services rendered, which are dependent on the competence of physicians, public health, nursing, and other necessary personnel. The organisation and methods of financial support should be formulated to maintain and improve that quality, not merely to provide services at low cost. It is obvious that the effective operation of any community-wide programme requires proper planning and administration. Hence, there is an urgent need for research in administrative medicine and the recruitment and education of a considerable number of qualified leaders in that field." (Stevenson, 1953).

The team method is now generally described as the essence of success as if this denies the idea of hierarchy, though even the smallest team must have a leader, implying some measure of hierarchic order. As in George Orwell's story, "Animal Farm"—

"All animals are equal, but some are more equal than others." In any complicated organisation there must be a hierarchy. The necessity for a rational direction of effort demands that one person be ultimately responsible to the political authority for executive duty.

I would not deny the usefulness of a *small* advisory committee representative of various professional interests (not to protect personal interests, but to contribute from professional knowledge) and headed by the medical officer of health in formulating advice on policy.

No doctor can know it all; the medical administrator cannot claim to be independent of expert specialised advice, both medical and non-medical. He must be educated, Dr. E. S. Rogers says, "not so as to achieve mastery in a particular area, but rather to know enough about important areas to have a set of values regarding them." (Stevenson 1953.) But he must relate scientific advice to public reactions; he must present it in a way acceptable to the political authority.

There are always lines of authority with team work at various levels. The chief administrator must delegate much of his work, especially on the business and organisation side, but since this last may, and indeed will, affect the professional work of the staff he must be in final charge. The Medical Officer of Health should, after advice and subject to his Council, be the arbiter on the content of the department's programme, of the records to be kept, of health education, of all the schemes for health preservation: and he must decide the priorities; the methods of implementation—the mechanics—are the means to the end and should be left very largely to his staff in their own spheres.

Our work as doctors is of high significance to the human race, but if at least some of us do not accept and discharge faithfully the responsibilities of administration in the sense in which it has been used in this paper, we lose our opportunities to do collectively, with public support, for the community what the family doctor of tomorrow will be doing for his individual patients—preserving and improving health in a changing social scene.

REFERENCES

- EMERSON, H. (1949.) *Administrative Medicine* (Nelson, New York).
FINER, S. E. (1950.) *Primer of Public Administration* (Muller, London).

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HEALTH AND ITS ASSESSMENT OR A TALE OF TWO BOROUGHS*

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There are at least two criteria which are very little prone to the subjective impressions of observers that demonstrate the health of a community. They are the Infant Mortality Rate and the Standardised Death Rate.

In Essex there are two adjacent communities, Dagenham and Ilford. Dagenham is largely inhabited by a working class population and Ilford contains a middle and lower middle class community. The Standardised Death Rate for 1952 in Dagenham was 11.97, that in Ilford 10.71. For the three years, 1949-1951 (these years have been combined to produce results more valid statistically) the Infant Mortality Rate in Dagenham was 29.2 and in Ilford 20, i.e. Dagenham has an I.M.R. almost fifty per cent. higher. Although the population of Dagenham is 113,200 compared with that of Ilford of 182,200, there were 30 deaths from tuberculosis in Dagenham in 1952 compared with 21 in Ilford, i.e. a rate of well over twice that in Ilford.

All this merely serves to prove that the standard of health in Ilford is higher than that in Dagenham, which is what one would expect as the average income in Ilford is higher, and, however much we medical officers of health pride ourselves on our services, the health of a community in Britain is largely dependent on the money in the pockets of its inhabitants.

We now come to quite different standards which are based on the subjective impressions of school medical officers.

TABLE
HEALTH AND ITS ASSESSMENT (I. Gordon)
1952

Dagenham		Ilford
113,200	Population	182,200
29.2	Infant Mortality Rate	20
11.97	Standardised Death Rate	10.71
30	Tuberculosis Deaths	21
19,958	School Population	23,403
5 women, 1 man	School Medical Officers	5 women, 1 man
7,724	Routine Medical Inspections	6,745
5,852	Other Medical Examinations	12,709
<i>Classification</i>		
79.21 per cent.	Good	36.2 per cent.
19.34 " "	Fair	61.0 " "
1.45 " "	Poor	2.8 " "
<i>Orthopaedic Defects</i>		
270 (3.5%)	Treatment	1,117 (16.6%)
94	Observation	408
<i>Nose and Throat</i>		
195	Treatment	390
184	Observation	619
<i>Ears</i>		
115	Treatment	48
155	Observation	127
52	Recuperative Holidays (July-September 1952)	20

* Paper read to the Refresher Course for School Medical Officers, London, April, 1954.

Medical Administration (concluded from p. 175)

- GORDON, J. (1954.) *J. Roy. San. Inst.* **74**, 449.
 MACAULAY, H. M. C. (1954.) *Lancet*, *i*, 148.
 MACNALLY, A. S. (1948.) *The History of State Medicine* (R.I.P.H.H. London).
 †MASSEY, A. (1937.) *Public Health*, **50**, 117.
 NEWSHOLME, A. (1936.) *The Last Thirty Years in Public Health* (Allen and Unwin, London).
 PARRY, R. H. (1948.) *Public Health*, **61**, 102.
 †——— (1952.) *Proc. Roy. Soc. Med.*, **45**, 113.
 STEVENSON, G. S. (1953.) *Administrative Medicine* (Josiah Macy Jr. Foundation; New York).
 †WALTON, W. S. (1954.) *Public Health*, **67**, 74.
 WARNER, R. (1947.) *Principles of Public Administration* (Pitman, London).

† Not quoted, but of interest in the subject.

Dagenham has a school population of 19,958, Ilford one of 23,403. To study this school population each borough has six school medical officers of whom five are women and one a man, in each case. No doubt they work according to somewhat different traditions which prevail in their respective boroughs but luckily for the purposes of this survey the results of the investigations have to be reported in standardised fashion for the County Council.

The old nutritional standards of A, B, C and D were discarded because of gross lack of concordant diagnosis and for it was substituted the three grades of "good, fair and poor." Here there is a startling difference in the two boroughs. In Dagenham 79.21 were "good," in Ilford 36.2. In Dagenham 19.34 were "fair," in Ilford 61.0. This result of course can only make one extremely sceptical as to the value of these figures and the waste of time in producing them to the second place of decimals.

When we come to certain specific defects, the differences are equally absurd. In Dagenham there were 7,724 routine medical inspections in 1952, in Ilford 6,745. Of orthopaedic defects, 270 requiring treatment, (i.e. 3.5%) were found in Dagenham but 1,117 in Ilford (i.e. 16.6%). Lest one might think that this was balanced by other defects being put down for observation and not for treatment in Dagenham, the difference nevertheless persists in this latter class, for there were 94 requiring observation in Dagenham compared with 408 in Ilford.

As far as nose and throat defects were concerned, in Dagenham 195 required treatment and in Ilford exactly twice that number, 390. In Dagenham 184 required observation and in Ilford over three times that number, 619. It is notorious that defects in these two classes are subject to greatly differing ideas among medical men. This does not apply of course in diseases of the ear such as deafness and otitis media, etc., which are usually simple observations. Here the picture is more as one would expect, for in Dagenham there were 115 requiring treatment and in Ilford 48.

Figures such as these must give rise to considerable doubt as to the value of medical officers' opinions concerning certain so-called disorders. One would get the impression from these figures, if one did not know the circumstances, that Dagenham children were far healthier than those of Ilford, but I do not think that even Dagenham medical officers would feel this, for in three months of 1953 they sent 52 of their school children away for convalescence whereas Ilford doctors only felt that 20 required this. It is obvious that the whole matter requires further analysis.

In the course of some years' experience, dozens of conditions have become apparent to me, both from my own observation and the studies of others, in which conditions there is a wide borderline as to what is normal and what is abnormal. I trust you will not mind if I refer mainly to small children and only to a less extent to school children as I hope that most of you do child welfare work as well as school medical.

These conditions are a heterogeneous collection, covering many specialties, and may roughly be divided into four groups.

(1) Conditions essentially normal, though deviating from a theoretical ideal of perfection: examples are the naevi found at the nape of the neck and bridge of the nose in young infants.

(2) Border-line states, such as enlarged tonsils or flat feet, in which clinical acumen is required to decide whether treatment is necessary or not.

(3) Conditions definitely pathological, in which, however, the necessity for treatment is extremely doubtful—for example, geographical tongue or the almost universal symptomless infestation with threadworms.

(4) Other conditions which are just frank misdiagnoses, such as the milk crust for seborrhoea capitis or the withdrawn testis for the maldescended.

Although many a physician will declare that he has known all about these conditions, experience has shown me that many others are unaware of the absence of the need for treatment. Furthermore, parents often worry and require reassurance.

Five Common Conditions

Five conditions stand out pre-eminently from all the others in importance, either by reason of the amount of public money that is unnecessarily spent on their treatment or by the effect that such treatment has on the later career of the individual.

I refer to (a) enlarged tonsils; (b) orthopaedic "defects" in children under 5, such as knock-knees, bow-legs, flat feet and valgus ankles; (c) phimosis in young infants; (d) constipation in breast-fed babies; and (e) innocuous cardiac murmurs and other sounds.

Enlarged Tonsils.—The extraordinary vagaries of the medical profession with respect to tonsillectomy have been discussed by Glover (1950), and the clinical indications (or lack of indications) by Illingworth (1950), who states that the appearance of the tonsils, unless they are so large as to cause obstruction, should never be a sole criterion for operation. Inadequate or careless surgery is also frequent (Gordon, 1947). Nevertheless, the profession continues stolidly on its way in recommending the operation, and the waiting-lists at hospitals are piling up to such an extent as to provide its own solution of the problem—an unfair solution, for those who require the operation are deprived of it.

Orthopaedic Defects.—Price (1949), states that "a very casual observation of the posture of normal children will refute the suggestion that the legs should be straight." In the first two years of life there should be a varoid phase with an outward curve and inward twist of the lower end of the leg. This is present at birth and compensated for by adduction and valgus movement of the foot. At about 2 years the knee becomes valgus, and this "deformity" is maximum at 4½ years and normal by the age of 6. At times there may be 2½ in. (6.3 cm.) between malleoli standing and 2 in. (5 cm.) lying. Stamm (1948) declares "flat-foot" in early childhood to be a myth, and insists on the far greater importance of deformities of the toes. Experience in infant welfare centres amply confirms the views of these two authors. Nevertheless, expenditure on wedges, special shoes, and splints continues at an unnecessarily high level. Recently Pickering Pick (1953), in a very interesting paper in *The Lancet* has suggested that the three so-called deformities of infantile flat feet, bowed tibiae and pigeon toes are the natural accompaniment of foetal posture in the very cramped quarters of the uterus, and recover spontaneously without wedged heels and remedial exercises.

Phimosis.—The subject of phimosis in early life has been admirably dealt with by Gairdner (1949). Whilst I feel that there is still room for discussion on the general advisability of circumcision, there is no doubt that in the early months it is impossible to tell if there will be phimosis in later life, and operations performed because of phimosis at this time have no scientific basis.

Constipation in Breast-fed Babies.—Constipation, in the sense of infrequent stools, in the breast-fed infant is entirely normal. Forty-one per cent of such infants in the third, fourth and fifth months of life do not have daily stools (Gordon, 1951) unless they are given purgatives, enemas, or some such treatment. It is possible that such measures may be the cause of chronic constipation in later life. Infrequent stools in later years are themselves a condition of doubtful moment if examination can exclude any serious disorder.

Innocuous Cardiac Murmurs.—Systolic murmurs in the heart have been the subject of much debate, and it is generally agreed that most of them are innocuous, while unnecessary attention or treatment leads to a neurosis. From my own experience I would have thought that the medical profession generally appreciated this, but Evans (1949) apparently considers that that is by no means yet the case, and he also remarks on the misinterpretation of the reduplicated first mitral and the accentuated first pulmonary sounds.

Other Conditions Causing Unnecessary Anxiety

There are also a large number of conditions in childhood that cause unnecessary anxiety and should usually be ignored. Some of them have not hitherto been discussed or sufficiently well defined and may require further investigation, but others will no doubt be considered obvious by some though misinterpreted by others.

Skin.—Nævi are often a cause of concern. The faint port-wine stains on the bridge of the nose (Airey, 1944) and nape of the neck in infancy are normal. The strawberry nævus disappears of its own accord (Lister, 1938). Small veins are seen on the back of the neck or opposite the insertion of the diaphragm (corona

diaphragmatica) more commonly in adults, and are of no significance. Small pearly-white milium sebaceous cysts are found on the face and nose, and less often elsewhere, in 40% of healthy infants. They disappear spontaneously, and are probably due to closure of hyperactive sebaceous glands by epidermis in the foetus (Gordon, 1949). I have known a case to be notified as pemphigus neonatorum. A red papular eruption on the face, less common than the sebaceous cysts and occurring later, is also harmless. Desquamation of the pink newborn infant and physiological jaundice are of course familiar. A bald patch on the occiput in infants is also common and soon remedies itself. The milk crust, a collection of oils and dirt over the anterior fontanelle, can be removed by soap and water if it is not secondarily infected by pityriasis simplex (Gordon, 1940). In cold weather an infant's hands often swell. This may be due to gloves being pulled off, and to tight sleeves; it has never, in my experience, given rise to any trouble. In hot summer weather mothers are often worried by the pigmentation that seems to be confined to a region just proximal to the finger-nails—sunburn. A blister is not uncommon in the centre of the upper lip, and in older children quite harmless scabbing occurs on the rim of the pinna of the ear. Mothers often complain bitterly of the sweating of their infants, but this is usually due neither to tuberculosis nor to rickets.

Nervous System.—It is here that it is most difficult to decide whether treatment is necessary or not. In the majority of the following cases the answer is against treatment: common tics, such as blinking; nocturnal enuresis in children under 5 years; masturbation and minor sexual mischievousness between small boys and girls; variations from the average in the amount of sleep required, and night terrors in small children in whom imagination is dawning; the small infant that jumps with a sudden noise, such as a sharp voice or the banging of a door; the head-banger, the breath-holder; morning sickness in the school-child who is anxious about his performance at school; the queer twisting of the hands of infants at 5-8 months of age that suggests athetosis but of course is not; nail-biting—18.6% of school-children bite their nails (Gordon, 1947). In all these cases precipitate action should not be taken, but the child must be considered carefully in its general reaction to stress. This subject is further discussed by Professor Capon (1950).

Mucous Membranes.—There is little relationship between the colour of the mucous membranes and the haemoglobin values (Adcock et al., 1950).

Eyes.—Epiphora, due to a blocked tear-duct, clears of its own accord in most cases. Strabismus in the newborn has of course not the serious import that it has six months later. Blue sclerotics in infancy rarely betoken fragilitas ossium.

Urinary System.—If ammoniacal urine in an infant over 3 months does not cause a rash it is not a disease of the child but an error of hygiene (Gordon, 1940). In cold weather frequency of micturition increases, and clean babies may relapse; in hot weather there is less urine, and mothers are often worried over the red sediment.

Breasts.—The common secretion from the breasts of newborn infants is of course physiological and not a mastitis. Boys at puberty may occasionally complain of tender and somewhat enlarged breasts.

Cardiovascular System.—Besides the murmurs mentioned above boys are commonly brought to the doctor with complaints of fainting, especially when standing for long periods. This is usually not of any significance.

Ears.—Pinnae that stick out unduly require treatment only exceptionally by a plastic surgeon. Strapping is probably useless. Many infants touch their ears when teething, and this is not usually due to pain or otitis media. Mothers when talking of "discharge" from an ear more often refer to wax than to pus.

Bones, Joints, and Muscles.—Not a few infants hold their heads to one side. This usually rights itself without treatment and is not then a true wryneck. Asymmetry of face and cranium is very common, and in most cases the mother can be assured the "defect" will not be noticeable in later years. A depressed calcified anterior fontanelle must not be mistaken for one that has not closed. A "lump" on the inner side of the foot proves to be the tuberosity of the tarsal navicular. Mothers are often worried by quite normal protuberances on the occipital and temporal bones. They can likewise be assured about cracking joints. Divarication of the recti in infants is also of small moment. The "growing pain" has been dethroned from its position as an important rheumatic manifestation and is now largely regarded as a consequence of minor orthopaedic deformities. I doubt even this. These pains require adequate investigation, especially so far as history is concerned, but most are innocuous.

Genitalia.—The maldescended testis may on more careful examination prove to be a normal testis drawn up by the cremasteric

muscle, especially if the weather is cold. The penis in the obese youngster with a suggestion of Frohlich's syndrome may have a disconcerting habit of disappearing in the fat of the pubic region.

Growth and Progress.—At about 1 year of age many children temporarily cease to gain in weight, or may even lose. This is probably due to increased activity when the child is beginning to walk. Some children are late in walking because they have developed a technique of getting about by other means. The speed of the "bottom-shuffler" has sometimes to be seen to be believed.

Lymphatic System.—D'Espine's sign—that is, bronchophony over the spinous processes at a lower level than usual—is not commonly an indication of hilar tuberculosis.

Larynx.—Small infants often have a quite harmless stridor and make many mysterious clucks and noises of little significance. The husky voice in toddlers is seldom the result of the papilloma on the vocal cords that we are warned about.

Conditions in the Alimentary Canal

Teeth may erupt at birth at or 1 year of age and yet be quite normal. Not uncommonly, there may be bleeding into the gum preceding eruption. The barbarous custom of incising the gum for these complaints is fortunately dying out, but has not yet quite disappeared. Grinding of teeth has usually no pathological significance. Dribbling does not forecast the imminence of eruption.

In infants the tongue may normally be kept protruded, deviate to one side a little if protruded, or not be kept still. A strawberry tongue does not always indicate scarlet fever. The geographical tongue is of no evil portent. "Tongue-tie" is almost invariably a figment of the imagination, and incision of the fraenum is not called for.

Besides the problem of enlargement of the tonsils, mentioned above, specks on the crypts often turn out to be food debris or small growths of a fatty or xanthomatous nature. The "won't eat" neurosis is more often a complaint of the mother than of the child. An infant that is contented and gaining well may regurgitate its feed to its heart's content. Curdling of the milk merely means that it has entered the stomach. Mothers often complain of halitosis in their children. Usually no cause can be found, and the child remains perfectly well.

Umbilical herniae in infants are so common that I doubt if we should call the smaller ones pathological. There is one condition in which an empty tag of skin protrudes from the navel; it is certainly not pathological, is not a hernia, and requires no treatment. Woods (1953), has very recently shown that one-sixth of all children have these herniae and 93 per cent. heal spontaneously within a year.

Mothers often complain about the stools of their healthy children. Green streaks turn out to be vegetable remains. With hard stools, or even with normal stools, streaks of blood may occur on one occasion: examination discloses nothing, and the condition may never recur. Threadworm infestation, if as common in England as in Holland (Schueffner and Swellengrebel 1943), which I suspect it to be, is almost universal and usually symptomless. Is it, then, a disease?

Discussion

Why do our school medical officers differ so much in their estimation as to what is disease and what is not? I personally feel that the blame must lie mainly with our teachers who in the past have not concerned themselves with this wide borderline between health and disease but have spent far too much of their time in discussing and teaching the rarest complaints of our children and then assuaging their conscience by promoting idealistic definitions of health. This attitude is now slowly changing, however, for some of the more modern paediatricians are taking a more active interest in the matter and even arrange that their assistants work as school medical officers and in infant welfare clinics in order to learn something of the great big world around them.

I have dealt entirely with children so far, but it must be realised that with the child, especially the infant, the problem is simplified, and is infinitely more difficult in the adult. For if the adult thinks he is ill, as he often does, then he is ill, but not necessarily in the connotation to which he attributes his malaise.

A few words about definitions of health, which in the eyes of many of our teachers must not be sullied by considerations of disease. For instance, Professor Capon (1945) has defined a large proportion of healthy children as follows—

"(1) The mucous membranes (e.g., the lips and palpebral conjunctiva) are definitely pink in colour. (2) The facial expression is happy, often radiant; smiling is frequent, and the eyes are bright and responsive. (3) The skin is smooth, elastic, and covers a sufficient layer of subcutaneous fat to give the limbs a rounded appearance. (4) The tissue-turgor is normal. (5) The muscles are well formed, and their tonus is good. (6) The limb bones are almost straight. (7) The stance is well balanced, erect, and graceful. (8) The spine is straight and the shoulder-girdles do not drop. (9) The arches of the feet are well formed. (10) The movements of limbs and body, in walking and running, are characterised by elasticity, agility, vigour, and poise."

This seems to me to be the description of an exhilarated ballet-dancer rather than the ordinary healthy schoolboy, were it not that ballet-dancers are said to have flat feet. The real danger of such an ideal, however, is that if a child does not conform to it it is considered necessary to see that he does, and steps are taken accordingly. That is, for example, if his conjunctivae are not pink enough, his legs not straight enough, his soles not arched enough, he must have iron by mouth, irons to his legs and wedges to his shoes, and undergo unnecessarily frequent examinations, causing unnecessary expense and unnecessary neurosis.

Professor Anjaleu, the Director in the Ministry of Health, Paris, has similar ideas and supports the WHO Constitution in which health is defined as "not only the absence of disease or infirmity but of a complete state of physical, mental and social well-being, which state of well-being can be acquired and to a great extent preserved by the observation of a certain number of rules which cannot form the subject of laws and regulations." Even one of our own best known medical officers of health has fallen into the trap and states he does not like considering sickness or mortality rates as a measure of health but talks about sparkling and positive health and joy to be alive, but has not mentioned how we are going to estimate the degrees of joy-to-be-aliveness. This state of health is often called "positive health." A well-known American commentator has rather bitingly stated that this expression is "a pitiful term smacking of journalistic superfluity." I feel strongly that the term positive health should not describe a state at all but the adjective positive be used to denote a striving or effort towards an ideal, which ideal cannot however be reached. Health cannot be considered apart from disease any more than good from bad or hot from cold; for that is the way the human mind works. It must be remembered that the human organism is continually evolving in its environment as is any other organism. It lives by using certain features of this environment and combating others. The environment itself is always changing. Occasionally among its features are the influenza virus type A and another time it may be the type B and yet another time it may be the smallpox virus; at certain times and places there may be ample nutrition of the right kind and at other times less. And either the ample or the less nutrition may at different times and at different places be good or bad for certain individuals. Where then is this ideal of positive health?

We must, however, although it is difficult, try to define what we mean by health. Statistics of heights and measures established among school children may help or hinder. It is well-known that the modern school child is now taller and heavier than his recent predecessor, and this is probably a sign of improved health. But it is now almost certain that this is only a more rapid maturation, for there is no evidence that the adult is taller than he used to be, and the stature of the adult is probably settled genetically. Let us not assume that the tall acromegalic is healthier than the Sherpa who climbs Everest. We are not helped by asking ourselves if any special case requires treatment, and if he does not then he is healthy. For there are obviously many conditions for which we can do nothing and yet they are of great significance. We cannot state that a man is healthy if he feels well and does not complain. One individual with a high blood pressure may

complain bitterly, another individual may have the same blood pressure but not complain. Is the former ill and the latter well? Obviously not; they both are ill but not suffering from quite the same thing. Then there is a "functional" school, which states that an individual is well if the disorder present allows him to perform his function in life satisfactorily—that is, a policeman with flat feet is unhealthy, whereas a typist is not. It is easy to pick holes in this argument, for so many of us have no useful function to perform, or, if children, do not yet know what our function in life is going to be. We may be old and retired, or in an asylum with schizophrenia; and to be logical this school will deprive us of the luxury of being ill by definition should we contract, say, tonsillitis. Again, two people may have precisely the same disorder and the same job. One—we all know him—will make the most of his trouble, and the other (we know him too, but not so well) will ignore it and continue to work as efficiently as before. Is the former ill and the latter well?

Then, even if a man feels well and functions well physical examination may disclose something of dire consequence for the future—for example, an early melanotic carcinomatous change in a mole.

It appears that the answer to this problem is a critical synthesis. We are healthy if we (a) feel well, (b) function well, and (c) if the objective signs of imperfection which we all can provide are such as besides allowing (a) and (b) in the present, give reasonable confidence that we may feel well and function well in the not-too-distant foreseeable future.

One advantage of this definition is that at least some of us can be defined as healthy by it whereas if we consider the idealists' definition of positive health we are certainly all ill. There are most important political and social consequences of this attempt to define health as apart from disease and to ignore the significance of the vague borderline, for if, as now happens, doctors who have not been suitably trained consider that the innumerable cases that lie in this 'twixt and 'tween territory require treatment, this must largely be paid for out of public funds since the introduction of the National Health Service. And as all of us, for some of the time, are in this ill-defined territory, it is certain that no national funds can properly stand the pressure. Further, the treatment of disease is in the National Health Service Act assumed to be the function of the Regional Hospital Boards and the local authorities are assumed to be responsible for those healthy; but again vast sections of the population are by definition neither one nor the other and each authority seeks to be absolved of the responsibility of caring for them. In common parlance, they fall in between two stools, with often the most distressing consequences; I refer particularly to the predicament of the aged who for much of their time are "half-way."

I trust that the fact of my criticising the importance of many of these childhood variations does not imply that they should not be recorded by skilled medical men. Many people believe that school medical officers are wasting their time in routine medical inspections and that teachers and nurses can pick out children initially. I trust that it is obvious that this would be entirely wrong, for the most difficult task in medicine is making decisions on these borderline cases and the most skilled and experienced physicians should do it.

Although I am the Divisional School Medical Officer for Ilford, I trust it is not felt that I am criticising the medical officers of Dagenham. I think just the opposite is the case, for the Dagenham medical officers have found far fewer cases in the, say, orthopaedic fields, that require treatment and I would not be surprised if they are correct. One doubt, however, assails me. Perhaps these differences do exist. Perhaps the middle class children in Ilford have more postural defects and more crooked limbs than the working class population of Dagenham. I greatly doubt it, but it is a matter on which people may wish to argue.

The central part of the address is based on a paper entitled "The Healthy Child, Its Many Disguises" which was published

in the *British Medical Journal* (1951), i, 611, and is reproduced by kind permission of the Editor.

REFERENCES

- ADCOCK, E. A., BERRY, W. T. C., COWIN, P. J., and MULLIGAN, E. H. M. (1950.) *Mon. Bull. Min. Hlth. P.H.L.S.*, 9, 88.
 AIREY, F. S. (1944.) *Proc. Roy. Soc. Med.*, 38, 142.
 CAPON, N. B. (1945.) *Arch. Dis. Childh.*, 20, 52.
 — (1950.) *Brit. Med. J.*, i, 859.
 EVANS, W. (1949.) *PUBLIC HEALTH*, 63, 3.
 GAIRDNER, D. (1949.) *Brit. Med. J.*, ii, 1433.
 GLOVER, J. A. (1950.) *Mon. Bull. Min. Hlth. & P.H.L.S.*, 9, 62.
 GORDON, I. (1940.) *Brit. Med. J.*, i, 383.
 — (1947.) *Brit. J. Soc. Med.*, i, 238.
 — (1949.) *Arch. Dis. Childh.*, 24, 286.
 — (1951.) *Lancet*, i, 1203.
 ILLINGWORTH, R. S. (1950.) *Proc. Roy. Soc. Med.*, 43, 317.
 LISTER, W. A. (1938.) *Lancet*, i, 1429.
 PICKERING, PICK, M. (1953.) *Lancet*, ii, 1339.
 PRICE, E. E. (1949.) *Med. J. Aust.*, 11, 589.
 SCHUFFNER, W., and SWELLENGREBEL, N. H. (1943.) *Zbl. Bakt. (I Abt., Orig.)*, 151, 71. Abstract in *Trop. Dis. Bull.* (1945.) 42, 922.
 STAMM, T. T. (1948.) *PUBLIC HEALTH*, 61, 158.
 WOODS, G. E. (1953.) *Arch. Dis. Childh.*, 28, 450.

COST OF THE NATIONAL HEALTH SERVICE*

1. The Society of Medical Officers of Health is grateful for the invitation to submit evidence to the Committee.

2. The Society includes in its membership medical officers of health, medical and dental officers in the local government service, school medical officers, medical superintendents, medical officers employed by Government departments and medical teaching staffs of universities, and has a numerical strength of approximately 2,200. The aims of the Society, as set out in its constitution, are to promote the advancement of public health by the practical and theoretical study of all questions relating to it.

3. The terms of reference of the Committee of Enquiry are:—

"To review the present and prospective cost of the National Health Service; to suggest means, whether by modifications in organisation or otherwise, of ensuring the most effective control and efficient use of such Exchequer funds as may be available; to advise how, in view of the burdens on the Exchequer, a rising charge upon it can be avoided, while providing for the maintenance of an adequate service; and to make recommendations."

In the light of the terms of reference of the Committee the Society has considered the National Health Service with a view to saving money on the one hand and to obtaining better value for money on the other. This can only be achieved by systematic day-to-day supervision and continuous scrutiny of expenditure by those who have the knowledge of medical needs and experience in medical administration.

4. The Society is of the opinion that the cost of the National Health Service is bound to rise, particularly on the hospital side, unless steps are taken to unify the service and to change it from being primarily a service for the relief of sickness to a real health service. Prevention is better, and cheaper, than cure. The Society is of opinion that before great changes in the organisation of the Health Services are made, a decision should be reached on what is likely to be the best form of administration and that all changes should be made in the direction of this ideal, and that no changes should be made which will make that ideal more difficult to achieve.

5. The Society considers that there should be a complete reorganisation of the Health Services to provide a unified administration of all three sections under elected representative bodies and based on local authority administration. A pre-requisite would be the reorganisation of local government and it is recognised that this is unlikely to be achieved

* Memorandum of Evidence submitted by the Society of Medical Officers of Health to the Committee of Enquiry into the Cost of the National Health Service (the Guillebaud Committee).

in the near future, but if ultimately there were a number of all-purpose authorities of reasonable population and area they could very well include within their functions the control of a unified Health Service.

6. These new controlling authorities would contain a majority of members elected by and responsible directly to those they serve, and would need expert impartial medical advice. The adoption of this principle alone would do much to prevent any waste. The duties of the Ministry of Health should be advisory and supervisory and not executive.

7. It is considered that by simplification of administration in the hospital services much money could be saved and that some of these savings should be used to finance an increase of public health measures which would lead in turn to further savings by reducing the need for therapeutic services. Thus a cycle of efficiency, progress and economy would be substituted for the present vicious circle of overlapping administration and ever-increasing cost.

8. The administrative bodies engaged in the National Health Service are the Ministry of Health, Boards of Governors, Regional Hospital Boards, Hospital Management Committees, House Committees, Executive Councils and Local Health Authorities. Each of them has many committees and sub-committees and offices, equipment, lay administrators, finance officers and general clerks. This multiplicity produces administrative waste and presents a field where savings could be made.

9. "He who pays the piper calls the tune" is a salutary maxim. Except in local government medical service, the National Health Service's piper is well out of earshot of the taxpaying caller. In other words, in relation to local hospital administration the best answer to the question "*Sed quis custodiet ipsos Custodes?*" is the local government elector.

10. Hospital administration should be the responsibility of Local Health Authorities. The transfer could be smoothly arranged if local government reorganisation were first carried out, but pending reorganisation interim arrangements could be made for hospital administration in areas comprising a number of complete local health authority units. If this were done Hospital Management Committees would be unnecessary. It would also be a step towards the establishment of the local control of hospital services.

If it is not possible to put this interim plan into operation soon, the Society considers that adjustments could be made which would either save money or make more economic use of the services already provided.

(a) Admissions to Hospital

Among the detailed functions of Regional Hospital Boards and Hospital Management Committees is that of controlling admissions to hospital.

The Society appreciates that the ultimate responsibility must rest with those controlling the hospitals but there are many diseases and conditions which have an important social and environmental aspect and the general practitioners and the medical officers of health should have a better opportunity of influencing the decisions to ensure the user of beds to the best advantage.

(b) Chronic Sick

Many chronic sick cases can be nursed at home if the relatives are given adequate help. It is a happier and more economical arrangement to keep chronic sick cases out of hospital wards when this is possible. When hospital beds are too few in number relative to the demand as they often are, a few chronic sick cases may block beds for a very long time which would otherwise have been available for many short-stay acute cases.

The extended provision of home nurses and home helps by Local Health Authorities would obviate the need for some of the beds at present used by chronic sick. This would require increased financial provision by the Local Health Authorities in exchange for either a more economical user of beds or an actual reduction in the number of beds. At present, the first alternative appears to be the more likely but it would be well worth while as a method of improving the hospital service greatly at little extra cost.

(c) Planning of Services

Local Health Authorities are properly required, before making changes in their activities, to send copies of their proposals to Hospital Boards. These Boards should be required to reciprocate. The interchange of planning information between the bodies administering the three sections of the National Health Service would avoid wasteful expenditure on the provision of overlapping or unnecessary services, e.g., the unnecessary provision of maternity accommodation in some areas.

(d) Maternity Services

There is considerable waste in some areas in providing expensive hospital accommodation for maternity cases who could be confined at home. The Society considers that cases should only be booked for admission to hospital for obstetric reasons and that cases recommended or seeking admission for medico-social reasons should be referred to the medical officer of health, who after consultation with the general practitioner and the midwife would arrange for institutional or domiciliary confinement as might be necessary. There are possibilities here of considerable savings without any detriment to the service.

Small maternity homes should be administered by Local Health Authorities. Here, the general practitioners could look after their own cases under perfectly satisfactory conditions without need for the high cost of consultant service and of expensive equipment provided in hospitals for abnormal cases.

(e) Health Visiting

This is an excellent service which pays good dividends in the improvement of the public health. The value of the health visitors would be further enhanced if all hospitals complied with the duty of providing information to the medical staff of local authorities about their patients on discharge where this is in the interests of the patients. It is understood that this failure arises from a confused conception of medical ethics in some hospitals which fortunately does not occur in most hospitals.

There is a danger of overlapping of duties of health visitors and hospital almoners. The Society agree with the dictum of the Ministry of Health that almoners should not normally visit the homes of patients. Any information required about home conditions can be obtained through the health visitor who alone is the family case worker.

(f) Ambulance Service

The Society is satisfied that the ambulance service is administered as economically as the demands made upon it allow. It is considered, however, that some of the calls initiated by the hospitals are unnecessary. Many abuses of the service would be avoided with consequent saving in expenditure if all departments in each hospital co-ordinated their needs by making a single officer responsible for the ordering of ambulances. This has already been done in many hospitals with excellent results.

(g) Recuperative Holidays in Convalescent Homes

Recuperative holiday homes are provided by the Local Health Authority and convalescent homes by the Hospital Service for the rehabilitation of sick persons. In many cases the reasons for admission to either of these types of accommodation are indistinguishable. The facilities should come under one control—that of the Local Health Authority—so that cases from general practitioners can get proper priority.

(h) Chronic Sick and Aged and Infirm

Here are two services under the control of the Regional Hospital Board and the Local Authority respectively, although the services provided are incapable of clear lines of demarcation. In the interests of effective administration and economic organisation, they should be brought under one control. The administration of the hospital service by Local Health Authorities would solve this problem.

Within the administrative field of the Local Health Authority, too, there is a division of responsibility. The Local

Health Authority as such has no responsibility for the institutional care of the aged and infirm, this being a matter within the control of the authority as a Welfare Authority. Welfare functions are not always dealt with by the Public Health Department even though the Medical Officer of Health is the medical adviser. On the other hand the Medical Officer of Health does have responsibility for certain aspects of home care under this section of the Act.

The Society considers that Social Welfare Departments are redundant and efficiency and economy could be achieved by placing all welfare administration in the hands of all medical officers of health of Local Health Authorities. This arrangement is in being in many areas and operates satisfactorily.

(i) *Care of Children*

The considerations indicated in (h) above apply also to Children's Departments which should be absorbed by Public Health Departments.

(j) *Occupational Health*

The view of the Society is that any future occupational health service should be part of the National Health Service and that the local authority is the best agency for the peripheral administration of the preventive side, with the general practitioner dealing with the clinical side in a part-time capacity. Thus, a service could be allowed to develop by evolution without undue expenditure.

(k) *Mental Defectives*

The Society considers that both domiciliary and institutional care should be the responsibility of the Local Health Authorities. A very large number of beds are provided by the Regional Boards for mental defectives, but even so they are not enough and this branch of their work tends to be neglected. Mental defectives need care only in that medical treatment cannot cure them. The supervision of patients on licence is the responsibility of the L.H.A. as also is that of providing hostel accommodation. The administration of all these sections should be united under one control.

The Society considers that functions in this connection should attract a grant of the order of about 90%.

(l) *Dental Services*

The Ministry of Health has inaugurated a scheme of training for dental ancillaries, whose duties are largely those of scaling, polishing, topical applications to dental surfaces and the teaching of oral hygiene. They are most desirable in a well-administered service. They would in no sense replace qualified dentists. Their most important sphere of work would be the priority and hospital dental service where considerable financial and manpower economies would be achieved.

POSTGRADUATE EDUCATION IN PUBLIC HEALTH OF MEDICAL PRACTITIONERS*

A. Introduction

1. In 1945 the Society of Medical Officers of Health put forward proposals on postgraduate education in public health to meet the immediate post-war needs. At that time, the National Health Service was in contemplation but had not yet taken definite shape. Five years have now passed since comprehensive medical care came into operation. It is now possible to obtain a clearer view of the needs of public health training. This further report has been drawn up with this in mind and the proposals are intended to meet the new situation.

Comprehensive medical care under the National Health Service Act, 1946, has focused attention upon the care and treatment of sick people. This has done much during five years of existence to improve the care of the sick person in hospital and at home. The significance of the Act to preventive medicine and the promotion of health is less easy to define. In many ways the operation of Part III of the

Act, by extending services of domiciliary care, has brought about improvement. But on the whole the emphasis upon curative medicine has over-shadowed the advantages of an organised approach to community health.

The need for public health is as great, or indeed greater, to-day than before 1948. When so much public money is being spent upon the treatment of disease it is imperative that the health officers should be fully supported in developing prevention. There is also the need for a comprehensive approach to the improvement of the health and welfare of the community as a whole. This is one of the means by which to ensure that there is a proper balance of expenditure between prevention and cure. Thus it is of great importance that this broader approach, which is developed by the training for the Diploma in Public Health, should be encouraged. As the avowed object of a National Health Service is to extend the work of prevention it is obvious that the greater the number of doctors in all forms of work who develop the preventive attitude and when possible take a special training in public health, the more speedily will this end be attained.

B. Statutory Qualifications

2. The Local Government Act, 1933, prescribes that no person shall be appointed a Medical Officer of Health of a County or Borough or Rural District of 50,000 population or more unless he holds a registered qualification in Sanitary Science, Public Health or State Medicine. (Similar requirements exist for London and Scotland.) The present requirements for training are defined in "Rules as to Course and Study and Examinations for Diploma and Degrees in Sanitary Science, Public Health or State Medicine" by the General Medical Council on November 28th, 1945 (in operation 1.1.46). The General Medical Council has given particular emphasis to the desirability that "the special privileges with respect to the tenure of the posts of Medical Officers of Health should only be enjoyed by practitioners whose diplomas or degrees sufficiently guarantee the attainment by them of a high standard of proficiency, scientific and practical, in all branches of study which concern the public health."

The Society strongly endorses the views of the General Medical Council. But they consider that the obligation to train for a Diploma in Public Health or other statutory qualification should not be limited, as in effect it is, to the Medical Officer of Health himself. The Diploma should normally be required by all Medical Officers of Health, their Deputies, Senior M.O.s and Assistant M.O.s in full-time service.

3. *Entry to the D.P.H.* The greatest flexibility should be retained in the matter of entry to the D.P.H. Course in order to make it possible both for graduates to undertake the training at the moment of most convenience to them, and to assist students from overseas, and also to make easier the interchange between various services for which the diploma is a valuable basic qualification. For these reasons the Society does not favour making regulations as to the experience to be obtained before entering upon the course. It is considered that graduates should be entitled to start the course immediately after registration.

Other methods of improving recruitment must be sought through financial aid. Graduates wishing to specialise in any other branch of medicine are now assured of reasonable means of support during their period of training. Those who train for the D.P.H. should be given a similar advantage. This can be achieved partly through the organisation of part-time courses which enable the graduates to earn during their training. However, this method generally depends upon the good will of local authorities and it does not meet the need of those students, who, of their own initiative, prefer to undertake full-time training for the diploma. Grant aid in some form is urgently needed.

C. Recognition of Merit

4. The attraction of most professional occupations to would-be entrants must be dependent upon two factors:—

1. The intrinsic value of the job as judged by the person who is looking to it as a life's work, and

* A memorandum prepared by a special sub-committee under the chairmanship of Prof. C. Fraser Brockington and adopted by the Council of the Society of Medical Officers of Health.

2. The esteem in which the work is generally held as judged by its status. The Society is convinced that a sufficient proportion of young graduates can and do appreciate the intrinsic value of health work. The ideal of preventive medicine, and the maintenance of a high standard of national health, appeals strongly, particularly to the young. In former times there was also little doubt about the second value. In the pre-National Health Service era, the status and emoluments to be attained by a health officer compared well with those to be won in most other branches of medicine. This parity of esteem should be supported and strengthened. The official scheme of merit awards which has been widely granted throughout the hospital service should be equally applicable to those who follow with distinction a career in public health. The work which they perform in many positions of great responsibility, which are only to be obtained after specialised training and usually after many years of experience, urgently calls for this recognition. Such awards should be made to individuals irrespective of the office held.

For such distinction the basic training for the Diploma in Public Health and the achievement of a higher qualification should be regarded only as a first step. Extensive experience in the work which is essential to good "Public Health," including research, would be desirable. Little difficulty would be found in laying down the basis of such experience, which would be not less than that demanded of specialists for hospital posts.

D. The Curriculum of the Diploma in Public Health

5. The Diploma in Public Health should aim at teaching the principles upon which the health of the community depends, and to show in operation as many of the practical applications of such knowledge as the time allows. Although it is to be presumed that the basic principles of how to preserve the health of community remain the same, their application will vary in different parts of the world and at different times in one part of the world. In a changing society the content must necessarily vary with the development of knowledge and technique.

In earlier years, in Western Europe particularly, the problem of the environment and spread of infectious disease occupied the forefront of the community health picture to the exclusion of much else. The earlier courses for the Diploma in Public Health in Britain, from the 1870s until well into this century, reflected this predominant characteristic; much time was allotted to the subjects upon which we had built our environmental health services, *e.g.*, the chemistry of water pollution, public health engineering and bacteriology. The changing epidemiological picture with its decline in lethal infections and the greater numbers living to older ages has introduced a two-fold change: (a) the search for the principles of healthy living has led us to explore beyond the immediate circumstances of the environment (and its infectious sequelae) into the background of people's lives among psychological, sociological, biological, nutritional, occupational and other allied factors: (b) the changing structure of society has required increasing attention to the aged, chronic sick and handicapped.

Further considerations have effected changes in the diploma content in Britain: (c) the increasing complexity of the machinery devised by Parliament to meet social needs particularly those designed to conquer the five giants, Want, Ignorance, Squalor, Sloth and Disease, and (d) the growing realisation that clinical medicine must embrace the social content of disease and in so doing must be interlocked with those other medical services (for the protection of community health) which have also encompassed the same social background. In short, public health is increasingly linked with medicine in hospitals, general practice and industry.

With these many variables it is neither desirable nor possible to lay down a too rigid curriculum. A course must be designed within a broad framework to minister to the needs of the students. It is certainly beneficial that the few

separate courses operating in Britain should develop along individualistic lines thus (a) ensuring a varied choice for both home and overseas candidates and (b) giving an opportunity for liberal experiment in a field which must constantly embrace new ideas. That which follows must therefore be regarded as no more than a "broad framework."

Many of the traditional subjects for the Diploma are, of course, fundamental and will not be dealt with in detail here. In addition to the fundamental subjects or in substitution for some of the existing subjects we consider that the Diploma should pay attention to some or all of the following aspects:—

(1) Occupational health should be studied in sufficient detail to enable the diplomate (a) to enter public health fully alive to the significance of occupation to health and able to play an important role in the direction of any occupational health service which may be devised, and (b) to enter industry as a full-time industrial medical officer.

(2) Education for health needs to be developed to embrace the social and psychological aspects of learning and to include an understanding of techniques of instruction, and visual and other aids. Public health officers and industrial medical officers should be in a position to undertake Health Education.

(3) The field of epidemiology of infection should continue to be expanded with particular emphasis upon the viruses, in order to enable the Medical Officer to be his own field epidemiologist. Clinical teaching of infectious and contagious diseases, both major and minor, should be continued.

(4) The increasing burden of mental illness and psychosomatic disorder calls for a two-fold development (a) that of teaching in the social aspects of psychiatry including child development and mental deficiency and psychiatry in relation to industry and old age and (b) the elaboration of studies of human behaviour in the fields of Social Anthropology and Social Psychology. The training in the ascertainment of the E.S.N. child should be incorporated in the D.P.H. Course.

(5) Emphasis should be given in the Course to the subject of child development and to the normal child.

(6) The social and epidemiological aspects of the main killing and disabling diseases should be presented. This calls for development of teaching in the non-infectious conditions which predominate in Great Britain. Attention should be given to categories of population subject to special risks, *e.g.*, the school child, the mother, the baby, the handicapped, the aged, etc. This will be the basis upon which services for the protection of the vulnerable classes can be expanded and developed.

(7) The Diploma in Public Health has always had as one of its main purposes the training of the medical graduates in administration. The development of the National Health Service has increased rather than diminished the need for such qualities in a proportion of the medical profession. The President of the Royal College of Physicians of London speaking to the Committee in his presidential address of 31.3.53 put this problem succinctly when he said: "The dilemma confronting almost every profession is whether its members shall concentrate on strictly professional work and lose the power to direct it, or learn administration so as to be able to remain in control of it, thus losing the time to practise it." The Society welcomes this statement as an expression of the clear need for administration by medical men which it has always advocated. To this end the administrative training afforded by the D.P.H. needs to be extended and developed to encompass the many new aspects of social welfare and health services including those of industry.

(8) The Society considers that the experience of the past eight years has shown that the taking of the examination for the Certificate in Public Health, after the first part of the D.P.H. Course, makes an unnecessary break in the continuity of the training for the Diploma.

Experience has also shown that there is no demand for the Certificate as distinct from the Diploma. The Society is, therefore, of the opinion that the Certificate in Public Health could now be dropped.

SOCIETY OF MEDICAL OFFICERS OF HEALTH COUNCIL MEETING

The Provincial Meeting of the Council of the Society was held at the Town Hall, Manchester, on Friday, 18th June, 1954, at 10 a.m.

Present: Dr. J. M. Gibson (in the Chair), Dr. C. Metcalfe Brown (President), Drs. C. W. Anderson, F. A. Belam, Professor C. Fraser Brockington, Drs. F. G. Brown, J. S. G. Burnett, H. D. Chalke, H. M. Cohen, H. K. Cowan, Sir Allen Daley, Drs. Miriam Florentin, F. Hall, C. Herington, J. H. Hudson, J. B. McKinney, A. A. E. Newth, Surg/Captain R. L. C. Proctor, Drs. T. Ruddock West, H. L. Settle, J. F. A. Smyth, Esq., Drs. J. A. Stirling, W. S. Walton, Elspeth Warwick, Nora Wattie, F. J. Welton, H. C. Maurice Williams, Professor G. S. Wilson, and Dr. J. Yule.

Drs. W. H. Bradley and A. V. Kelynack were also present.

Welcome by the Mayor: Before the commencement of the Meeting the Lord Mayor briefly and cordially welcomed the Council to the City of Manchester and the Chairman in reply thanked the Lord Mayor for the hospitality which was being extended to the members.

Apologies for Absence were received from the following: Drs. A. Anderson, R. T. Bevan, F. Buchan, Sir John Charles, Drs. W. G. Clarke, T. M. Clayton, C. K. Cullen, F. M. Day, R. H. G. H. Denham, W. G. Evans, James Fenton, G. M. Frizelle, F. Gray, A. S. Hebblethwaite, John Maddison, W. R. Martine, Maurice Mitman, Hugh Paul, G. H. Pringle, A. G. Reekie, Brig. A. E. Richmond, Drs. J. Riddell, F. R. Waldron, E. J. Gordon Wallace, Anne Mower White, W. Woolley, Andrew Topping.

131. Membership of Council.—It was reported that Dr. F. J. Welton had been nominated a member of the Council in place of Dr. R. M. Orpwood. Dr. Welton was welcomed by the Chairman.

132. Dr. Andrew Topping.—It was reported that Dr. Andrew Topping was unable to attend the meeting because of injuries received in a motor accident during his recent visit to Africa. It was resolved that a letter be sent to Dr. Topping wishing him a speedy recovery, and also congratulating him on the award of the C.M.G. in the recent Honours List.

133. The Minutes of the Meeting held on Friday, 19th February, 1954 were confirmed and signed by the Chairman, subject to the following amendments:

Minute 80, The Minute should read as follows: "It was resolved that the Council supports the nominations of Dr. H. D. Chalke and Dr. H. K. Cowan to serve on the Council of the B.M.A. for the Session 1954/55."

Minute 86, The words "The Staff Side of" to be inserted before the word "Committee" in the last line of the Minute.

134. Functions of the Medical Officer of Health.—(*Min. 73*).—It was reported that the draft document on the Functions of the Medical Officer of Health had now been revised and that copies would be circulated during July so that members would have ample time to consider it before the matter is formally considered at the September Meeting of Council.

135. Training of District Nurses.—(*Min. 78*). Copies of the Memorandum of Evidence submitted by the Society were before the Meeting and the document was endorsed. **Appendix (A).** It was reported that a copy of the Memorandum of Evidence submitted by the British Medical Association had also been received for the information of the Society.

136. Consultations between the Society and Government Bodies.—(*Min. 85*).—Dr. H. L. Settle, on behalf of the Yorkshire Branch, drew the attention of members to the issue by the Ministry of Health of Circular 26/53 in which it was reported that a Committee had been formed to Consider the Welfare Arrangements for Epileptics and Spastics.

137. Food Hygiene Regulations.—(*Min. 89*).—It was reported that following the last meeting of Council comments had been prepared by the Standing Committee for Food Matters and then forwarded to the Ministry of Food. A second Draft of the Regulations had now been considered by the Standing Committee and comments were in course of preparation for submission to the Ministry.

138. Presidency of the Society 1945/55.—It was reported that originally two nominations had been received, one by the Maternity and Child Welfare Group in the name of Dr. Jean M. Mackintosh, and the other by the County District Group in the name of Dr. J. D. Kershaw, who subsequently, with the consent of the County District Group, withdrew his name. In the letter

of withdrawal Dr. Kershaw expressed the opinion that women medical officers of the public health services, in view of their notable contribution to progress, have undoubtedly earned the highest recognition which the Society could give them, and that from this group of officers there was no one more worthy than Dr. Mackintosh to receive such recognition.

Dr. Kershaw said that both on this and other grounds he would not wish to prevent Dr. Jean Mackintosh from becoming President of the Society.

Dr. H. M. Cohen, on behalf of the Midland Branch, informed the members present that although no official letter had been sent the Midland Branch had unanimously endorsed the nomination of Dr. Jean Mackintosh and he asked that the Midland Branch's name should be associated with the nomination.

The Chairman thereupon formally declared that the nomination of Dr. Jean M. Mackintosh should be submitted for election by the Ordinary Meeting to follow.

139. Officers of the Society for the Session 1954/55.—The following were elected officers of the Society for the Session 1954/55.

(a) *Chairman of Council.*—Dr. H. K. Cowan.

(b) *Three Vice-Presidents.*—Dr. C. Metcalfe Brown, Dr. Andrew Topping, Dr. J. M. Gibson.

(c) *Hon. Treasurer.*—Dr. C. Herington.

(d) *Hon. Solicitors.*—Messrs. Neish, Howell & Haldane, 47 Watling St., London, E.C.4.

140. Co-option of Members to serve on the Council for the Session 1954/55.—Nominations being invited for the co-option of members to serve on the Council for the Session 1954/55, the following names were submitted for ballot at the September Meeting of Council:—

Article 19(d) Drs. James Fenton, W. G. Harding, E. K. Macdonald, Hugh Paul, Llywelyn Roberts, H. C. Maurice Williams.

Article 19(f) Sir John Charles, Sir Allen Daley, Professor C. Fraser Brockington, Professor G. S. Wilson.

(Dr. George Buchan had informed the Chairman that he did not wish to be reappointed.)

141. B.M.A. Public Health Committee.—It was reported that the usual invitation had been received from the British Medical Association for the Society to appoint two members to serve on the Public Health Committee of that organisation. It was resolved that Drs. H. M. Cohen and Llywelyn Roberts be appointed the Society's representatives.

142. Report of the General Purposes Committee.—Dr. H. K. Cowan presented the report of the General Purposes Committee, held on Friday 9th April, 1954 (Appendix B.).

Min. 100. Whitley Medical Functional Council

(a) *Committee "C"*—Dr. A. V. Kelynack submitted a verbal report on the discussions at the last meeting of the Staff Side of Committee "C".

(b) *Special Sub Committee*—Dr. H. K. Cowan referred to the recommendation of the General Purposes Committee regarding the formation of a special Sub Committee to consider the question of remuneration generally, and said that if the conclusions of such a sub committee were to be of any use to the Staff Side of Committee "C" it was essential that the Committee should meet at an early date and proceed to its final conclusions as expeditiously as possible. It was accordingly resolved that the following be appointed a Sub Committee in accordance with the recommendation: Drs. T. Ruddock West, J. Yule, F. A. Belam, J. H. Hudson, R. T. Bevan, C. W. Anderson, Miriam Florentin, Nora Wattie, together with an Assistant Medical Officer and a Divisional Medical Officer to be appointed by the Chairman of Council after consultation with the Officers. (Subsequently the Chairman has agreed that the names of Drs. Hilary J. Crewe, Assistant, and G. O. Mitchell, Divisional Medical Officers of Health, be added to be membership of the Committee.)

Min. 102. Training of Health Visitors

It was reported that representatives of the Society had attended a meeting of the Health Visitors Working Party, on Thursday, 27th May, and that the Working Party had asked for a further document to be submitted in amplification of certain points discussed at the meeting.

Min. 104. Civil Defence.

Members had before them copies of the draft memorandum from the Ministry of Health and of the document prepared by Dr. W. S. Walton. It was resolved that the Society approve the draft circular to be issued by the Ministry and that together with the letter giving such approval there be forwarded the document prepared by Dr. Walton, with a request that the points set out

therein be considered for inclusion in a draft circular on training to be issued at a later date.

Min. 105. Occupational Health Committee.

It was reported that following the Joint Meeting referred to, a letter had been received from the B.M.A. in which detailed questions were set out on which the B.M.A. Committee would like further information. The matter was referred to the Occupational Health Committee of the Society.

Min. 106. Cost of the National Health Service.

- (a) *Evidence of the Society*—A Draft Memorandum of Evidence prepared by the Sub Committee set up by the Council was considered and approved in the form attached (Published separately in this Volume).

A letter was received inviting the Society to appoint representatives to give oral evidence, on the 29th June. It was resolved that the following represent the Society on this occasion:—Drs. C. Metcalfe Brown, Sir Allen Daley, Drs. J. M. Gibson, F. Hall, T. Ruddock West, Nora Wattie.

- (b) *Evidence of the British Medical Association*—Members had before them copies of the amended versions of the Paragraphs 89 and 92 of the Memorandum of Evidence submitted by the British Medical Association. The amendments were noted.

Min. 108. Research.

It was reported that a meeting of the Research Committee had been held on 13th May, and that Dr. H. D. Chalke had been appointed Chairman in the place of Dr. H. K. Cowan.

Dr. H. D. Chalke submitted a verbal report of the meeting and stated that it was the Committee's desire to co-opt further members to the Committee from the membership of the Society, with a view to the formation of a small Working Party which would report to the main Committee. It was agreed that as the Research Committee had already power to co-opt it could go ahead with its proposals.

Min. 112. Royal College of Nursing.

Dr. Hall reported that he had now had an interview with representatives of the Royal College of Nursing and gave details of the discussions on the following subjects:

1. Attendance of Public Health Nurses at Royal Sanitary Institute Health Congresses.
2. Nurses required to attend Court to give evidence.
3. Laundry facilities provided for the sick, elderly infirm.
4. Care of the Handicapped.
5. Legal position of the nurse in relation to certain duties undertaken at clinics, e.g. taking venous blood specimens.
6. Transfer of information from School Health Records to Youth Employment Officers.
7. Harmful effects of frozen fruit juices (ice-lollies) on children.
8. Lectures to Student Nurses—Lecturers fees.

Min. 122. School Health Service.

It was reported that a further approach on the question of the reference of matters dealing with the school health service to groups other than the School Health Service Group was to be made by the County Group.

Min. 123. Conference on Venereal Diseases.

It was reported that the Council of the B.M.A. had approved the statement considered at the meeting of the General Purposes Committee, subject to the amendment of sub paragraph 1(a) of Paragraph 7 to read as follows: "To extend the practice of blood examination for all pregnant patients, not only in the first but also in subsequent pregnancies." Following the meeting a letter had been forwarded to the Ministry of Health submitting the document for the information of the Minister and asking for an opportunity of discussing the matter with the officers of the Ministry. It was reported further that subsequently officers of the Ministry had discussed the statement with representatives of the B.M.A.

It was resolved that a letter be addressed from the Society to the Ministry supporting the action of the B.M.A. and concurring with the views expressed in the statement.

Min. 127. Visit of British Doctors to the U.S.S.R.

It was reported that following the meeting of the General Purposes Committee the officers had agreed that the name of Dr. Peter Edwards be submitted for inclusion in the party to visit the U.S.S.R. This action was confirmed.

Subject to the above amendments and additions the Minutes of the General Purposes Committee were received, and the recommendations contained therein adopted.

143. *District Nursing Records.*—It was reported that a Meeting of the Sub Committee on District Nursing Records had been held on the 26th May when Dr. J. D. Kershaw had been appointed the Chairman. A further meeting of the Sub Committee was to be held on the 7th July.

144. *Air Pollution.*—It was reported that an invitation had been received from the Committee on Air Pollution for the Society

to furnish observations and suggestions which would be helpful to the Committee. In view of the fact that such comments had to be forwarded by the 15th June, comments were sought from certain members of the Society and a memorandum forwarded to the Beaver Committee (Appendix C.)

This action was confirmed.

145. *Royal Sanitary Institute.*—A letter dated 9th April was received from the R.S.I. suggesting the setting up of a Liaison Committee to facilitate the interchange of ideas and the discussion of matters of common interest to the Society and the Institute.

It was resolved that the President, Chairman of Council, and the Medical Secretary be authorised to meet representatives of the Royal Sanitary Institute to discuss the proposals further.

146. *Training of Mental Welfare Officers.*—A letter, dated 11th May, was received from the Royal Medico-Psychological Association, inviting the Society to nominate members to serve on a Joint Committee to consider the training of Mental Welfare Officers. It was resolved that Drs. H. M. Cohen, Elspeth Warwick, T. Ruddock West and F. Hall be appointed representatives of the Society in this connection.

147. *British Dental Association.*—The attention of members was drawn to the publication in the issue of the British Dental Journal dated May 4th of an article on the dental health of children. It was agreed that the matter be considered at the next meeting of the General Purposes Committee and that the Dental Officers Group and the School Health Service Group be invited to make comments on the article at that meeting.

148. *Slaughterhouses.*—It was reported that a letter, dated 22nd April, had been received from the Ministry of Food, asking for the comments of the Society on the Draft Model Byelaws relating to Public and Private Slaughterhouses. On the authority of the Chairman of Council, comments prepared by the Standing Committee for Food Matters had been forwarded to the Ministry. This action was confirmed.

149. *Annual Dinner.*—It was reported that the Officers had discussed arrangements for the Annual Dinner to be held early next Session, and that it had been decided to hold the Annual Dinner this year at the Connaught Rooms, on Thursday 25th November. The main point of the change was to achieve a reduction in the price of the tickets (which this year would be 22s. 6d.) and to increase the popularity of this function with the members of the Society. The Hon. Treasurer stated that if good support were coming this year it would be possible still further to reduce the price of tickets to one guinea each.

150. *Purchase of Duplicator.*—The action of the Hon. Treasurer in authorising the replacement of the existing duplicator in the Central Office by an automatic model, at the cost of approximately £80, was confirmed.

151. *Representation.*—The following were appointed representatives of the Society on the bodies and the occasions stated:

- (a) *Royal Sanitary Association of Scotland*—Annual Congress, Dundee, 6th/10th September. Dr. Jean M. Mackintosh.
- (b) *Sanitary Inspectors Association*—Annual Conference, Southport, 7th to 10th September. Dr. J. S. G. Burnett.
- (c) *National Smoke Abatement Society*—Annual Conference, Scarborough, 22nd to 25th September. Prof. I. G. Davies.
- (d) *North Regional Association for the Deaf*—Executive Council. Dr. J. L. Burn.

152. *Life Membership.*—The following members being duly nominated by their respective branches were confirmed for election at the next Ordinary Meeting of the Society:

Yorkshire Branch: Dr. J. M. Gibbons, formerly M.O.H. Huddersfield C.B. Joined the Society in 1920.

Metropolitan Branch: Dr. M. T. Morgan, C.M.G., M.C., formerly Port M.O. Port of London, Joined the Society in 1919.

E. Anglian Branch: Dr. G. L. Leggat, O.B.E., Formerly Deputy M.O.H. Norwich C.B., Joined the Society in 1920.

Welsh Branch: Professor R. M. F. Picken, formerly Mansell Talbot School of Medicine, Provost Welsh National School of Medicine. Joined the Society in 1912.

E. Midland Branch: Dr. M. L. Bery, formerly M.O.H. and S.M.O. City of Lincoln. Joined the Society in 1924.

There being no other business, the meeting was declared closed at 12.30 p.m.

APPENDIX A

WORKING PARTY ON THE TRAINING OF DISTRICT NURSES.

Evidence Submitted by the Society of Medical Officers of Health.

The Society are glad of the opportunity of giving evidence to the Working Party, whose terms of reference are:—

"To consider what training it is desirable that registered nurses and enrolled assistant nurses respectively should under-

take prior to their employment on home nursing duties, and the means by which such training should be provided."

The Society have considered the questionnaire issued by the Working Party and submit the following answers. Although the Society realise that present circumstances are such that some modification of the training arrangements for district nurses is necessary, they wish to emphasise the growing importance of the Home Nursing Service and the necessity of securing for that Service as adequately trained and experienced nurses as possible. They have had this principle in mind during the preparation of this memorandum.

I. General

(1) What should be the minimum length of the training that a nurse should undertake prior to taking up employment on home nursing duties?

The Society are of opinion that the nurse must receive full hospital training for State-registration as a general nurse, and that it is desirable that thereafter she should have a further year in hospital either as a staff nurse or as a ward sister, and if possible it would be desirable that she should gain experience during that year in paediatrics and geriatrics, but the Society do not wish to stipulate these two fields of nursing. What she does require is further experience in hospital. She should then have training in district nursing for a period of not less than four months. The Society suggest this shortened period from the one at present in operation of six months' duration for the following reasons:

- As the standard of life improves, the need for improvisation in nursing technique steadily lessens.
- Nowadays local health authorities usually provide materials, e.g. bedding, etc., where needed, so lessening the need for improvisation.
- The introduction of antibiotics and sulphonamides has in many respects simplified nursing treatment.
- The nurse does not require to be given so many lectures in the field of special diseases, nutrition and dietetics, environmental hygiene, and health, welfare, and social services as are laid down in the syllabus of lectures of the Queen's Institute of District Nursing. What is required is that the nurse should be a good practical nurse and have sufficient knowledge of the various social and medical services to enable her to direct the patient and his family, for the appropriate source of advice when necessary. The Society are of opinion that these special lectures might be reduced quite considerably, say from approximately 35 to approximately 20.

(2) By what means should such training be provided, e.g. by each local health authority, or group of local health authorities, or by some central body?

(3) How many training centres should be provided, where should they be located, and how should they be staffed?

With regard to the organisation of the training and the examination, national standards are essential. This means a national body. The Society are impressed by the standards of work of the Queen's Institute of District Nursing and are of opinion that the Institute is the best body to carry out this training and examination. They feel, however, that the Institute does need to be strengthened by the inclusion of an adequate number of Medical Officers of Health and certain members of their staffs intimately associated with the Home Nursing Service. This arrangement would virtually entail the setting up of a new Examination Board under the auspices of the Institute of control the training and examination of all candidates for the Home Nursing Service throughout the country.

The locus of training should be in large local authorities. It is undesirable to have a number of small areas or groups of areas responsible for training. The Society do not feel that they can go into the details of the numbers of training centres which will be required. This would have to be worked out in the light of the numbers of nurses required for the Home Nursing Service and the number each centre could train. With a reduction of the training period to four months, three courses per annum could probably be undertaken at each centre. They recommend that each centre should be large enough to have adequate arrangements to secure training in adjacent rural areas.

(4) What should be the conditions of acceptance for training?

As has already been indicated, the possession of a certificate of registration as a State-registered nurse is considered essential, with further hospital training. There should not be any age limit. The first month of training should be a probationary period. If the candidate is accepted thereafter and is in receipt of a training allowance, she should be required to give one year's service as a district nurse after the completion of her training. This is the practice at present of the Queen's Institute of District Nursing.

II. Pattern of Training

(1) How much of the total training time suggested at item (1) above should be devoted to theoretical training?

Out of the total four months' training period the Society think that probably about three weeks should be devoted to theoretical lectures.

(2) What system of theoretical training should be adopted, e.g. study days or block periods of study?

The Society do not feel they can be dogmatic on this point. Different training centres would find one or other method the more suitable.

(3) What should be the content of this theoretical training? Please give details under main subject headings of the number of lectures recommended and by whom it is suggested they should be given.

Reference has already been made to the Society's view that the number of lectures should be reduced. They have examined the Queen's Institute's syllabus and make the following recommendations:—

Subject B should be reduced from 10 to 8; Nutritional and Dietetics from 3 to 1; Environmental Hygiene from 2 to 1; and Health, Welfare, and Social Services from 12 to 7.

The Society recommend that the student should receive among the special lectures at least one from a general practitioner, and that in the practical work she should spend some time, perhaps a day, with a general practitioner, going round with him and getting to know the problems that arise in general practice from day to day.

(4) What should be the extent of a student's practical work? Please give full details, e.g. practical demonstrations both at the training centre and the patients' own homes, visits to hospitals, clinics, etc., supervised experience and the type of cases to be attended.

The Society wish to stress the importance of gaining experience in practical nursing in the home. They are doubtful whether visits to hospitals are really necessary, but recommend that the visits of observation to local authority activities are important.

III. Examinations

The Society are of opinion that some form of examination is necessary.

(1) What tests should be given during the period of training?

Any examination during this period should take the form of tests given by the tutors, and the report at the end of the probationary month should include the result of one such test and the standard of the practical work carried out by the candidate.

(2) Should a student district nurse be required to undergo a qualifying examination at the end of the course of training? If so—

(a) What should be the extent of the final theoretical examination?

(b) What should be the extent of the final practical examination?

A qualifying examination at the end of the training period is, in the Society's view, essential. A written paper should be answered and the candidate should carry out home visits under supervision so that her practical capability can be assessed.

APPENDIX B

GENERAL PURPOSES COMMITTEE

A Meeting of the General Purposes Committee was held on Friday, 9th April, 1954, at 10 a.m. in the Committee Room of the Society.

Present: Dr. H. K. Cowan (in the Chair). Dr. J. M. Gibson, (Chairman of the Council), Drs. H. D. Chalke, C. K. Cullen, F. M. Day, Miriam Florentin, F. Hall, C. Herington, Maurice Mitman, A. A. E. Newth, T. Ruddock-West, J. F. A. Smyth, Esq. L.D.S., Drs. J. A. Stirling and H. C. Maurice Williams.

Drs. T. M. Clayton and W. S. Walton were also present.

Dr. A. V. Klynack, Assistant Secretary of the B.M.A., attended as an observer.

Apologies for Absence were received from Drs. C. Metcalfe Brown and A. G. Reekie.

Welcome to Dr. Hall. The Chairman extended a hearty welcome to Dr. F. Hall who was attending the Meeting for the first time in his capacity as Medical Secretary.

99. Minutes of the last Meeting.—The Minutes of the last meeting of the Committee, held on 11th December, 1953, (Public Health, April, 1954, pp. 118/120) were confirmed and signed by the Chairman.

100. **Whitley Medical Functional Council.**—

(a) **Committee "C"** Dr. A. V. Kelynack submitted a verbal report on matters which had been dealt with since the last meeting of the Committee.

(b) **Salaries of County Borough Medical Officers of Health.** A statement of the County Borough Group of the Society, giving the reasons for their submission that there should be an appropriate "Weighting" in the Salary scales for County Borough Medical Officers of Health was received. A general discussion on this submission ensued and it was agreed that the Society, in considering salaries and conditions of service should concern itself with general principles only. *It was resolved to recommend to Council* that the Staff side of Committee "C" be asked to review the whole question of Salaries in the Public Health Service, and that, in order that some guidance could be given to the Staff side, a Sub-Committee be set up to consider the general principles of relationship between the various salary scales in the Public Health Service and to receive and consider any memoranda submitted by the Branches and Groups—the Sub-Committee to be representative of each section of the Society.

101. **Branch and Group Grants.**—(Min. 34).—The Hon. Treasurer reported that he had received the appropriate accounts in connection with the Yorkshire Branch's application for financial assistance, which had been referred to the Committee by the Council of the Society. After hearing the Hon. Treasurer's report, it was *resolved* that a special grant of £20 be made to the Yorkshire Branch.

102. **Training of Health Visitors.**—(Min. 35).—It was reported that a further meeting of the Sub-Committee had been held on the 31st March, and that arrangements had been made for the Society's representatives to give oral evidence on Thursday, 27th May. The Committee *confirmed* the Sub-Committee's suggestion that the representatives of the Society on this occasion be as follows:—Professor C. Fraser Brockington, Drs. J. S. G. Burnett, J. M. Gibson, J. Riddell, J. A. Stirling and Nora Wattie.

103. **D.P.H. Committee.**—(Min. 36).—It was reported that a letter was to be addressed to the Chief Medical Officer of the Ministry of Health, enclosing a copy of the report of the D.P.H. Committee. Arrangements were being made in the office for the compilation of any statistical information which might be required.

104. **Civil Defence.**—(Min. 37).—A letter, dated 30th March, from the Ministry of Health, enclosed a memorandum on the Functions of Medical Officers of Health in relation to Civil Defence, and asked for the Society's observations. The Committee considered this memorandum in the light of a document submitted by Dr. W. S. Walton on this same subject. It was *resolved to recommend to Council* that subject to minor amendments, Dr. Walton's memorandum be submitted to the Ministry as the Society's observations on the official memorandum.

105. **Occupational Health Service.**—(Min. 39).—It was reported that a Joint Meeting between the Occupational Health Committee of the Society and the Planning Sub-Committee of the Occupational Health Committee of the B.M.A. had been held, at which were considered the reports on the Pilot Surveys carried out by certain Medical Officers of Health and by an Industrial Medical Officer. It was understood that there was a possibility of the publication of the summaries of these surveys.

106. **Cost of the National Health Service.**—(Min. 40).—It was reported that a letter had been received in which it was stated that the Society's evidence to the Guillebaud Committee would have to be submitted by the 30th June. A draft document would be considered at the Council Meeting in Manchester on the 18th June.

107. **Investigation of Hospital outbreaks of Puerperal Infection.**—(Min. 42).—Dr. H. K. Cowan reported that discussions had taken place on this matter at the Ministry of Health. It was understood that a communication was to be expected from Sir John Charles.

108. **Research.**—(Min. 43).—It was reported that arrangements were being made for a meeting of the Research Committee early in May.

109. **Duties of Nurses.**—(Min. 51).—It was resolved to defer consideration of this matter until the next meeting of the Committee when it was hoped that Dr. Robert Forbes would be able to be present. In the meantime it was *resolved* to circulate to members of the Committee copies of the note of the meeting of representatives of the Society, the British Medical Association, the Institute of Hospital Administrators, the Medical Defence Union and the Royal College of Nursing, on the legal position of the nurse undertaking procedures outside her professional scope.

110. **Dismissal of Medical Officer of Health, N. Ireland.** (Min. 59).—It was reported that following the representations of the Society (through the N. Ireland Branch) and the B.M.A., the Northern Ireland Ministry of Health had agreed to hold a public

enquiry in this connection. At the first session the hearing had been adjourned.

111. **College of General Practitioners.**—(Min. 60).—It was *resolved to recommend to Council* that an approach be made to secure the attendance of an observer from the College of General Practitioners on the Council of the Society, and of an observer of the Society at meetings of the College.

112. **Royal College of Nursing.**—(Min. 61).—It was reported that a letter from the Secretary of the Royal College of Nursing expressed regret that it was impossible for representatives of the College to attend this meeting of the Committee. It was reported that arrangements were being made for Dr. F. Hall to discuss the matters involved with the Secretary of the College.

113. **Infectious Diseases.**—(Min. 77).—Further consideration was given to the letter dated 18th December from the Chief Medical Officer, Ministry of Health, which suggested that it might be possible for individual Medical Officers of Health to obtain information on a confidential basis from local laboratories about the incidence of non-notifiable infectious or communicable diseases in which they were particularly interested. The Chairman of the Council reported on discussions which he had had with the Chairman of the Council of the B.M.A. It was *resolved to recommend to Council* that in the reply to Sir John Charles thanking him for his letter, there be incorporated the method by which his suggestion might be carried out without jeopardising the relation between the General Practitioner and his patient.

114. **W.H.O./U.K. Committee.**—Dr. H. K. Cowan reported verbally on the Conference at which it had been decided to set up a United Kingdom Committee of the World Health Organisation.

115. **Meat Inspection.**—(Min. 91).—It was reported that a meeting of the representatives of the Society, the British Medical Association and the Sanitary Inspectors had been held on Friday, 19th March. Following the meeting the Society and the Sanitary Inspectors had forwarded letters to the Ministries of Health, Food and Agriculture and Fisheries supporting the action already taken by the B.M.A. and expressing strong disagreement with the statements made in the memorandum submitted by the British Veterinary Association, and stating that the three bodies were in full agreement on the following fundamental principles:

1. that meat inspection, being closely related to the health of both individual persons and the community as a whole, must be regarded as a Public Health service.

2. that it should be administered by Local Authorities.

3. that medical officers of health and sanitary inspectors are the appropriate officers to control and execute this work.

A Sub-Committee of this Joint Meeting was held on the 31st March, at which had been agreed a document which had been subsequently submitted to the three Ministries, jointly by the three associations, amplifying the points made in previous correspondence (Published in Public Health, May 1954).

116. **British Tuberculosis Association.**—(Min. 93).—It was reported that Dr. J. F. Warin was unable to take part in the forthcoming Conference at Oxford and arrangements had therefore been made for Dr. J. F. Galloway, Wolverhampton C.B., to take his place.

117. **Local Government Administration.**—(Min. 94).—Dr. T. M. Clayton gave a comprehensive report on the action taken by the Council of Coventry C.B. following the Survey undertaken by the O. & M. Division of the Treasury.

118. **Appointment of C.M.O. West Riding.**—It was reported that a letter, dated 30th March, from the Ministry of Health, informed the Society that it was understood that the West Riding County Council was taking steps to secure the appointment of a Medical Officer of Health as soon as possible.

119. **Abolition of the Fever Register.**—The Committee received for information documents which showed the action taken by the British Medical Association in collecting information regarding the reaction of various hospitals to the proposal to abolish the Fever Register. It was reported further that a Circular dated 6th April from the Ministry of Health, addressed to Hospital Management Committees, made it clear that the Ministry had no intention at present of agreeing to the proposal of the General Nursing Council for the closure of the Fever Nursing Register.

120. **Form of Consent for Immunisation.**—A letter from Dr. R. T. Bevan referred to the problem of obtaining consents for immunisation and the difficult legal position of Medical Officers of Health regarding their liability in the event of complications arising in the children immunised. The Committee carefully considered the points raised by Dr. Bevan but was of opinion that it should be left to Medical Officers individually to satisfy themselves as to their legal position.

121. **Provincial Meeting of Council.**—The President's proposals for meetings and functions at the Provincial Meeting to be held in Manchester on the 18th June were approved.

122. School Health Service.

- (a) The question of the need to refer matters relating to the School Health Service to groups other than the School Health Service group was carefully considered and it was agreed that there was no necessity to change the present procedure.
- (b) It was reported that the British Medical Association had had its attention called to a problem arising in connection with alleged non-cooperation between the School Health Service and General Practitioners with regard to the referral of children by the School Health Service to consultants and specialists. It was *resolved* that the Medical Officer of Health in question be informed that the existing arrangements in his area were not in accordance with the agreement between the Society and the B.M.A., and that therefore the Society would support any action taken by the Public Health Committee of that organisation.

123. Conference on Venereal Diseases.—It was reported that a letter, dated 26th February, from the B.M.A. had invited the Society to appoint representatives to attend a Conference on Venereal Diseases. After consultation with the Chairman, the following members had been invited to represent the Society: Drs. E. B. Argles, L. Meredith Davis, F. Hall, R. C. M. Pearson, J. S. Logan, T. Ruddock West. Representatives of the Public Health Committee and Venereologists Group Committee of the B.M.A. also attended the Conference, together with representatives of the Medical Society for the Study of Venereal Diseases.

The Committee had before it the Minutes of the Conference, and it was *resolved* to approve the recommended Joint Statement of Policy as follows:

(1) Social work should be an integral part of the V.D. Service—this principle has been expressed by a large majority of physicians in charge of V.D. Clinics.

(2) The Staff of every clinic should be such as to ensure that social work can be undertaken by a suitably experienced person or persons who should remain attached to the same clinic or clinics without being changed more frequently than is absolutely necessary.

(3) Social work undertaken at the clinic should include interviewing patients at the clinic, securing the attendance, by visit or otherwise, of contacts, i.e. persons known or believed to be sources of venereal infection, and securing the re-attendance of persons who have discontinued treatment prematurely.

(4) Staff engaged on social work should carry out their duties in the area served by the clinic without strict regard to local authority boundaries.

(5) The cost of providing staff for social work in the V.D. service might, in certain circumstances, be apportioned between the hospital authority and the local health authority concerned, on an agreed basis. Where more than one local authority is concerned, the cost might well be shared according to population.

(6) With the object of securing full co-operation between venereologists and medical officers of health in the prevention of venereal diseases, arrangements should be made where possible for venereologists in charge of clinics to be attached to the public health departments of the local health authorities of the areas served by their clinics; and that the procedure described in paragraph 6 of Ministry of Health circular 5/48, for protecting medical officers engaged in V.D. work from actions for slander etc. be applied to venereologists attached to public health departments for the above purpose.

(7) (i) With the object of securing a further diminution in the incidence of congenital syphilis, every effort should be made in hospitals, ante-natal clinics, and general practice:

- (a) to extend the practice of testing pregnant patients for venereal disease, not only in their first but also in subsequent pregnancies;
- (b) to seek the co-operation of the consultant venereologist in any case of doubt.

(ii) Special attention should be given to the importance of avoiding delay in reporting the results of tests.

124. Mental Illness and Mental Deficiency.—A letter, dated 27th February, invited the Society to submit evidence to the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. It was *resolved* that the following be appointed a Sub-Committee to prepare evidence in this connection: Drs. H. K. Cowan, F. Hall, J. S. Logan, A. A. E. Newth, E. M. Jenkins and Lilywelyn Roberts.

125. Accidents in the Home.—A letter, dated 15th March, from Dr. J. B. S. Morgan, in his capacity as Hon. Secretary of the Sheffield Pre-Liaison Committee, was referred to the Maternity and Child Welfare Group.

126. Registrar General's Quarterly Return.—It was reported that a letter, dated 25th March, from the Registrar General informed the Society that it was proposed to discontinue Publica-

tion of the Quarterly Figures of Population, Births, Deaths and Marriages in Counties, Great Towns, and Smaller Towns, which at present appeared in Tables IV, V and VI of the Quarterly Return. It was *resolved* that no objections be raised to the proposals.

127. Visit of British Doctors to the U.S.S.R.—It was reported that a letter had been received from the Society for Cultural Relations with the U.S.S.R. referring to an invitation for twenty British medical men and women to visit the Soviet Union in September this year. The letter invited the Society to forward some names for consideration by the organising committee. It was *resolved* that the invitation be left over for the consideration of the Council.

128. Certificate of Fever Nursing.—A letter, dated 30th March, from the Education Officer, General Nursing Council, forwarded for the comments of the Society a copy of the suggested revised syllabus of subjects for examinations for the Certificate of Fever Nursing. It was *resolved* that the matter be referred to the Fever Group, with power to act.

129. Committee Procedure.—It was *resolved* to recommend that the Officers of the Society be appointed a Sub Committee to consider the question of Committee procedure, with special reference to the confidentiality of recommendations to the Council, made by the General Purposes Committee, and to the suggestion by the Editor of Public Health that in future the Minutes of the General Purposes Committee and of the Council should not be published in full in Public Health, but that an abbreviated report of the business transacted at the meetings should appear shortly after the Meetings.

130. Representation.—A. *Handicapped Children.*—A letter, dated 28th February, from Dr. Simon Yudkin, invited the Society to appoint a representative to a Conference to be held at Church House, Westminster, on Saturday, 8th May, at which would be considered the problem of children suffering from mental or bodily handicap. It was *resolved* that Dr. A. A. E. Newth be appointed the Society's representative on this occasion.

B. The following were appointed representatives of the Society:

- i. *B.S.I. Sub-committee*—Examination and Physiotherapy Couches. Dr. A. A. E. Newth.
- ii. *Central Council for Health Education*—Council 1954/55. Dr. E. K. Macdonald and Dr. H. C. Maurice Williams.
- iii. *Registered Plumbers Association*—Council, Nottingham, June 4th. Dr. William Dodd.
- iv. *Regional Housing and Planning Conference*—London Region, Wednesday, 26th May. Dr. F. M. May.

There being no other business the meeting closed at approximately 12.55 p.m.

APPENDIX C

COMMITTEE ON AIR POLLUTION

Introduction

The Society of Medical Officers of Health have pleasure in submitting a memorandum to the Committee on Air Pollution.

No attempt has been made to include all the possible considerations which the Society could bring before the notice of the Committee, for it is known that the Committee have received evidence from a number of bodies (particularly the National Smoke Abatement Society) with which members of the Society find themselves, speaking generally, in broad agreement. It is intended, therefore, that the Society's evidence shall be brief.

The Society offers its fullest co-operation in attempting to prevent and to deal with problems of air pollution. In particular the Society wishes to state that medical officers of health are primarily responsible under the Sanitary Officers' Regulations (Article 17) 1935, "to keep themselves informed on all matters... likely to affect the public health in the district and be prepared to advise the local authority on any such matter." For many years the Society collectively, and its members individually, have striven against great difficulties to bring about a cleaner atmosphere and they will do all in their power now and in the future to assist the Committee in every possible way.

Legislation

The Society considers there is need for a consolidation of legislation on the subject of air pollution; that it should be simple and clear in enforcement and administration and that it should be nationwide in extent. It is suggested that smoke is a social nuisance and that it should be regarded, by the very fact of its existence, as a legal nuisance. Subject to provisos that a slight emission of smoke of less than 2 Ringlemann (and for certain periods of lighting up, soot-blowing and "excepted" processes) smoke should be regarded as a legal nuisance independent of its colour, density or duration.

There is need for simplification and clarification of the law relating to smoke from locomotives.

Industrial Aspects

It is recommended that an attack be made first on industrial smoke. Many firms are co-operating by the installation of modern equipment. In this connection it may be pointed out that while it is understood that the installation of new plant is subject to tax relief, efficient maintenance of such plant is not. It is felt that those firms which seek to improve their existing plant by alterations should receive some tax relief.

With regard to the "excepted" processes, it will be recognised that the present list is out of date and the Society will support the call for a complete review of all the processes regarded as "excepted."

The Society recognises the value of alkali inspectorate and would welcome an increase in the number of such inspectors. It is suggested that this inspectorate, whilst based on central headquarters, should have regional offices in the largest centres of population, so that the advice of these inspectors could be more readily available.

A decisive increase will be necessary in the scale of present measures for the training of staff, such as stokers, with the object of lessening industrial smoke. Some inducement of a material kind should be offered to men who successfully undertake such a course and are granted a certificate. At present the rewards vary widely from nil upwards.

The Society is greatly concerned over the gaseous and particulate matter emitted from power station chimneys controlled by the British Electricity Authority. It records its alarm at the building of so many power stations in areas where there is a large population. The Society is far from satisfied that the measures in use for precipitating the particulate matter are as efficient as they should be, whilst even greater concern is expressed over the possible harmful effects of the wide dissemination of gases such as oxides of sulphur. It is noted that the emission of sulphur dioxide can be as high as ten million cubic feet per day and the Society earnestly hopes that the Committee's recommendations will lead to the abatement of what might be a serious danger to health.

Domestic Smoke

The Society recommends that the Committee will favourably consider inducements to the householder, whether in municipally or privately owned houses, to use modern appliances (where these are not already installed) and to the use of smokeless fuel. It recognises that much education of the public is needed to this end and it pledges itself that it will do all in its power to further this end. It is appreciated, however, that much will depend on reducing the price and improving the reactivity and other qualities of smokeless fuels.

The Society believes in the implementation and extension of policy of smokeless zones and has heard from its members favourable reports of the working of the "condition of tenancy" clause in Council estates, whereby smokeless fuel only is burnt. The Society wishes to reinforce the evidence of other bodies in requesting that there be provision for smokeless zone powers in general legislation.

Research

The Society urges strongly the necessity of research into many aspects of air pollution. It deplores the ignorance of fundamental facts in present knowledge. It would urge that the help of University Departments be engaged in carrying out further research on the effect of the various pollutants upon human and animal health and upon agriculture. It would point out that a body such as the Medical Research Council might well initiate research into the differential incidence of respiratory disease and mortality in various centres of population throughout the country. It is noted, for instance, that the incidence of chronic bronchitis appears to be over four times as high in south-east Lancashire as in country areas. It suggests that areas be chosen where there is a high rate of atmospheric pollution as compared with control areas of low or minimal pollution. It suggests that research (both retrospective and prospective) in vital statistics might yield valuable results.

Lastly, the Society is much concerned with the implementation of the recommendations which the Committee will make, remembering the fate of several previous reports. It earnestly hopes that the recommendations of the Committee on Air Pollution will be effective and acceptable. It recommends that a permanent department be instituted, possibly as a section of the Ministry of Housing and Local Government, which will be charged with the task of carrying out and extending the Committee's recommendations on this most important aspect of environmental hygiene.

DENTAL OFFICERS' GROUP

President: Mr. S. B. Newton, L.D.S.

Hon. Secretary: Mr. J. F. A. Smyth, L.D.S. (P.S.D.O.), Gloucestershire.

An Extraordinary General Meeting of the Group was held in the Old Library, B.M.A. House, London, on Saturday, March 20th, 1954. In the absence of the President, the Vice-President, Mr. K. C. B. Webster, presided and was supported by ten other members and visitors. The Hon. Secretary read the notice convening the meeting and read through the proposed Group Rules as revised by a special sub-committee and approved by the Group Council. The Chairman explained that the alterations were minor ones and brought the Group Rules up to date. The only significant change was the proposal that the title of the Group should be altered to "Dental Group." On the proposition of Mr. Smyth seconded by Mr. Rubra, the new rules were agreed to by the unanimous vote of those members present.

A meeting of the Group was held at B.M.A. House, on the afternoon of Saturday, March 20th, when in the absence of the President owing to illness, Mr. K. C. B. Webster occupied the chair. In all, there was an attendance of 11 members and visitors.

Obituary.—The Chairman spoke of the many years of devoted service given to the Society, and to the cause of Public Health in general, by the late Sir George Elliston. He had been a sincere friend of the Group and it was largely owing to his efforts that the School Dentists' Society was amalgamated with the Society of Medical Officers' of Health in 1921. The meeting stood in silence as a token of respect for his memory.

Minutes.—The Minutes of the previous General Meeting were read, approved and signed. Apologies for absence were received from the President (Mr. S. B. Newton), Miss Forrest, Messrs. Fletcher, Robertson, Dinsdale, Duffield, Fleming, Sykes and J. Young.

Acrylic Filling Materials

The Chairman then introduced Mr. G. A. Morratt, B.D.S., D.D.S., Head of the Department of Conservative Dentistry at the Eastman Dental Hospital, and called upon him to speak on the above subject. Mr. Morratt, who illustrated his talk throughout with a series of excellent lantern slides, said that in the laboratory acrylic resins for artificial dentures were processed by the application of heat and pressure for a considerable time. For direct fillings in the mouth, such a technique was impossible and the principle employed was to use monomer plus polymer together with an activator. It was necessary at the same time to find some method of controlling shrinkage.

There were three types of acrylic filling materials. Type I (amino-peroxide) contained a tertiary amine in the monomer and hydrogen peroxide in the polymer. The first of these materials was introduced into this country following research work in Germany. The activator was in the liquid, and polymerisation started at the periphery, and as a result serious shrinkage took place. Further materials followed, using an aromatic amine. These set more quickly, but pressure applied by a special form of clamp was required and discolouration occurred after a short time in the mouth. Another material using a trepal ester in the monomer appeared less liable to discolouration.

Type II acrylics used a sulphuric acid activator, but as this was unstable and affected by moisture it was put up in an oily silicone base. The colour stability in this type of material was much greater.

Type III (Sulphur-peroxide) used a lauryl mercaptan activator put up in tablet form with benzoyl peroxide in the polymer. The advantage of this type was that it was less affected by moisture, and the technique for its use was to soak the tablet of activator in a few drops of monomer and then to add the powder, mixing them together on a slab. A silicone barrier cream was provided for use with cellulose acetate strips.

Recently a new Type I material had been introduced. It had been believed that the discolouration in this type of acrylic had been due to impurities in the tertiary amine and claims were now made to have produced a colour stable filling material.

Mr. Morratt said that control of shrinkage could be considered under two headings: technique, and the use of adhesives. One technique was a use of pressure applied with the finger or by means of a clamp or composition matrix. For Type I the brush method had been advocated. A fine

brush was dipped in the liquid and then in the powder, and the mix thus obtained was applied direct to the cavity, the filling being built up in stages. This somewhat difficult technique often resulted in an excess of monomer which was detrimental to the dental pulp. With another material of this type, the activator was first inserted in the bottom of the cavity and the monomer plus polymer inserted on top. In this way polymerisation began from within. With Types II and III acrylics, adhesives were generally used. Mr. Morrant here showed a micro-photograph indicating slight penetration of the dental tubules by the cavity seal.

The slab mix required the use of finer grains of polymer, and it could be shown that more air was trapped than with a liquid mix. In America a number of experiments had been carried out on the physical properties of acrylics, and it had been shown that co-efficient of expansion of acrylics was seven times greater than that of the tooth substance. Ice cream, therefore, caused over-contraction, and heat over-expansion. If a filled tooth were immersed in iced water and then dried and warmed, moisture was found to exude around the filling even when a cavity seal adhesive had been used.

Mr. Morrant emphasised the importance of correct finishing of the filling. The flash should be removed with a scalpel, followed by a finishing burr. Special files were also useful and polishing could be carried out with rubber cups and a polishing paste of zinc oxide and alcohol to give a high finish. At the Eastman Dental Hospital they had tested the effects of acrylic fillings on the dental pulp. Teeth which were to be removed for orthodontic reasons were filled and sectioned after extraction. Some reaction in the dental pulp had been observed even with the smallest cavities, but it only became acute when the dentine barrier was thin. A lining of oxyphosphate cement was, therefore, indicated in all but the shallowest of cavities. Lining materials containing eugenol could not be used.

Summing up the usefulness of acrylic filling materials, Mr. Morrant said that for tips of teeth and large restorations they were inferior to gold inlays. They lasted longer than synthetic fillings especially in labial cavities and in mouths liable to staining. In the United States opinion was hardening against

direct acrylic fillings, but in his opinion they had a future if the technique was carefully followed. They were unsuitable for jacket crowns owing to the danger of damage to the dental pulp. It had recently been estimated by a colleague of his that about 3,000,000 dental tubules were opened in a jacket crown preparation.

A lively discussion followed, in which the following took part: Miss M. Cosh, Mr. Oliver, Mr. Rubra, Mr. Taylor and Mr. Cohn. A vote of thanks to Mr. Morrant for his most interesting address was moved by Miss Cosh and carried by acclamation. The Chairman then spoke briefly of the award of the Industrial Court and its implications and Mr. Kew asked that the thanks of members to the staff side of the Dental Whitley Council should be recorded. Mr. Webster said that this would be greatly appreciated as the staff side had done a great deal of work in connection with the preparation for the hearing of the case.

The Hon. Secretary announced that the next meeting would be held on Saturday, May 29th, when Mr. E. Brebner, Principal Dental Officer for Health Education in New Zealand, had promised to speak. The Annual Dinner of the Group would be held at Zion College on the evening of Friday, May 28th, when Mr. Pickthorn, the Parliamentary Secretary to the Ministry of Education, would be amongst the guests.

NORTH-WESTERN M. & C.W. and S.H.S. Sub-Groups

President: Dr. Hilary Crewe (A.M.O., Stockport C.B.).

Hon. Secretary: Dr. E. M. Jenkins (Sen. S.M.O., Manchester, C.B.).

A meeting of the Sub-Groups was held in the Public Health Committee Room, Third Floor, Town Hall Extension on Friday, January 29th, at 5 p.m.

Pre-Pubertal and Pubertal Disorders

Dr. David Fletcher Shaw, M.R.C.O.G., consultant obstetrician and gynaecologist, Stockport and Burton, was then introduced by the President, who said how fortunate we were in having with us, as a consultant, the illustrious son of an

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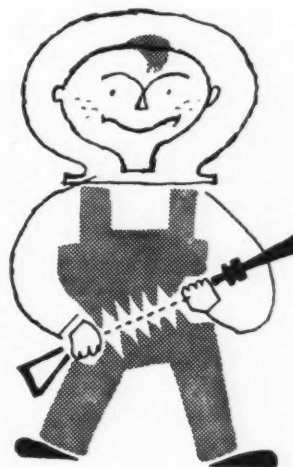
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illustrious father who was a well-known consultant in this city before him.

Dr Shaw prefaced his remarks with thanks for the invitation, and explained that this was a very wide subject and a difficult one to deal with in the short space of half an hour or so. He proposed to deal with the physical changes that occurred and the underlying endocrine imbalance during the transitional phase of change between childhood and adolescence. He thought it quite an appropriate subject for members of the sub-groups, and one which could with advantage be explained by medical officers to parents, who would then be better able to handle the difficulties arising at such a time in their children and the need for parents to warn their children of impending changes.

The average age at which these changes become manifest was 13.9 years, but anything from 9 to 17 years could be considered normal. The age was influenced by hereditary, racial, climatic, environmental, nutritional circumstances, and, of course, disease. Puberty affected the mental as well as the physical well-being of the adolescent, and it was well to consider how much this influenced a child's attainments during this difficult period of years.

Dr. Shaw then went on to discuss briefly the effect of the endocrine glands and the use of glandular treatment at this period. He explained that the pituitary was probably the main controlling gland, but that as yet our knowledge of the effects of all of them was still uncertain, and that generally speaking, their use in treatment was undesirable. Sometimes, due to endocrine imbalance, the physiology of puberty was abnormal, which might result in delay or early onset, the latter being called precocious. Abnormal changes might result from diseases, such as adrenal cortical tumour, mid-brain and hypophthalamic tumours, encephalitis, internal genitalia with delayed development, aplasia of ovarian tissue, basal adenomata of pituitary and deficiency of thyroid secretion, as in cretinism.

In treatment, Dr. Shaw advised as a general rule masterly inactivity, certainly none before the age of 17 years when cure was often spontaneous. No vaginal examinations should be made in children, except under an anaesthetic. There was a very definite danger of overdosage of the male hormone in the female which might produce masculinisation.

The diagnosis of cause was often difficult, but such examinations as estimation of endocrine secretion in blood and urine were probably of doubtful value; basal metabolic rate, sugar tolerance tests and x-ray of the pituitary, might be helpful.

Anatomical defects of the female were often undiscovered until too late, i.e., after menstruation had occurred; occlusion or absence of the genital tract resulted in large haematoma in the tubes, etc., causing irreparable damage before being discovered. Even after treatment such cases were likely to be infertile.

Dr. Shaw then mentioned briefly certain of the defects which occur at puberty, such as obesity, due to hyothyroidism or cretinism with resultant Frölich's syndrome, and the fat boy.

In the case of vaginal discharges, one should always remember gonorrhoea which was treatable by penicillin and a possibility often ignored by the gynaecologist. In diagnosis, vaginal swabs were not satisfactory, cervical little better, but a carefully taken urethral swab was diagnostic. The presence or absence of certain inhabitants of the tract, yeasts, Doderlein's bacillus, etc., indicated normal or abnormal conditions.

Dysmenorrhoea was fairly common, particularly in persons leading a sedentary occupation, but it had to be extremely severe to be considered strictly abnormal.

A short discussion only followed, as this most interesting talk had lasted rather longer than was usual.

A vote of thanks to Dr. Shaw was proposed by Dr. Maxwell Reekie.

BOOK REVIEW

Studies in the Social Services. By S. M. FERGUSON and H. FITZGERALD. (Pp. 367. Price 22s. 6d.) London: H.M. Stationery Office, 1954.

These studies in the social services have as their main theme the welfare of the family in this country during the second world war. Readers a generation hence will marvel at the "resourcefulness" of the family in changing and challenging circumstances. Hosts of problems were bound to arise, for example when four and a half million men (including two and a half million husbands) served in the forces often hundreds and sometimes thousands of miles away from home. Two hundred and twenty-two thousand

houses were destroyed and there were over sixty million civilian changes of addresses! Again, it is small wonder that so many troubles occurred when millions of women worked in the factories, when colossal schemes for evacuation were set in motion, and when maternity services, billets and hostels (in some areas) had to be set up almost over-night. These are examples taken at random from the studies of the authors who have taken good advantage of the opportunity of having access to official and unpublished documents.

Here are related the problems which troubled the minds of all who cared for the public health; of wartime promiscuity and the plight of the unmarried mother and her child; residential nurseries fitted with makeshift equipment and—of which we are more than ever conscious to-day—the risks of tuberculosis to the family. We are reminded of the shortages of rubber teats, contraceptives and "prams" in 1944.

But some good came out of it all. There was the breaking down of the taboo of venereal diseases—the "family" view of tuberculosis was given its rightful prominence by recognising that tuberculosis brings special problems, not only to the individual but to the family. The spontaneous yet resourceful help of the voluntary workers and the W.V.S. was magnificent in time of trouble. The Mass Miniature Radiography Service, which has probably saved many lives and certainly much suffering, was inaugurated. Various services for the family (such as that provided by the home helps) were developed almost out of recognition. Diseases such as scabies proved to be something more than a nuisance, and here again the importance of spread of infestation and disease within the family was clearly realised.

We who stand so near to the great changes which have occurred in public health services find it difficult to recall the poverty of our services before the war. One of the best accounts the reviewer has ever read of the problems of illegitimacy is given by the authors. It has a fine undercurrent of history which will well repay study.

It was during the war, too, that so many became conscious of the deprived child. The care of the aged and the value of the individual was more highly realised. Public conscience was shocked at a variety of disclosures—whether it was in the infestations in our towns or problem families or when it heard of adoptions taking place in public houses and fish queues.

It is of interest and value for our own times to read of the rigid (and frigid) Treasury control which frustrated so much good work in pre-war days. An excessive fear of spending money inhibited proper provision in the social services. What many authorities feared most of all was to "overstep the bounds of current Treasury sanction." A frequent type of question was "Is it possible to assist mothers (returning from evacuation) without incurring additional expenditure?" "The Treasury ban on pre-evacuation expenditure lasted right up to 25th August, 1939." Such phrases recur throughout the whole book. There is an interesting difference of attitude shown on the question of tuberculosis allowances. Said the Minister of Health "We want to throw the light of hope on tuberculosis." Said the Treasury—"Allowances are an investment in labour to be paid only if there was a definite chance of the patient returning to work in the foreseeable future." Limits of eligibility were closely defined and even narrower definitions had been suggested to the Treasury. Yet common sense often prevailed and the authors (on p. 280) seem to paint a more gloomy picture than really existed. Certain "arrangements" between Tuberculosis Officers and those doing the administration usually resulted in all new cases and very many old ones receiving assistance—auditors were known to be scarce during the war!

The last chapters recount the provision of the all-important staff to do the job—the nursing services.

The authors must be congratulated on (almost) succeeding in avoiding the temptation of being wise after the event. Their account—well written, well documented and well printed—is a permanent contribution of the story of some past and present problems in public health and social services.

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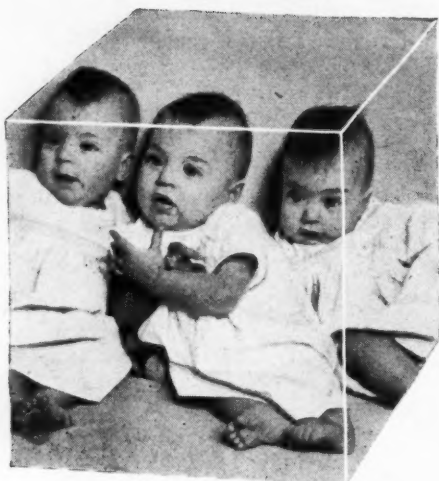


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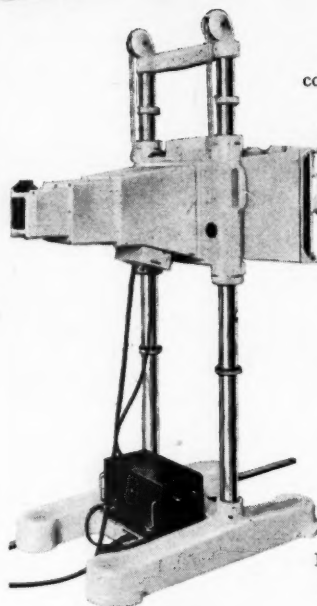
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